			For State Registrar		State of	Marylan		artment rtificate			and M	lental Hy	giene Reg. No.	HUb	38	001		
	Physici	200	1. Decedent's Name		•				-			2. Date of Dea	ath Day	Year	3. Time	of Death		
	/Medic		OK SOC									NOV 10		2006	5	РМ		
*	Examin	er	4a. Facility Name (If n				_			Location o		_	4c. County of Death					
			RAN DO LP I 5. Social Security Nur			G HOME		STL If Under 1	VER	If Under:	RIN		MONTGOMERY					
	Funeral Director		213 02 1		1 M 2 M F	96	Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Da AUG . 20	y, Year)	Year) 9. Birthplace (State or Foreign Country) KOREA				
	P		Usual Residence of D									A00.20	, 10	TO NO	TULA			
	arylar show	_		10b. County	OMEDV		, Town or Lo		C						10d. Inside	•		
	he M	Director	MD	MONTG	OMERI	311	VER S									es 2 No		
	with a or		10e. Street and Numb		DD			10f. Zip (zen of What Co	untry?			
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9	or iter		1 Never Married	d 2 Marrie	Armed Ford	es? 2 T No	1				, Puerto	ecify Yes or No- Rican, etc.)		Black, White	e, etc.			
9	72 hours after death with the Maryland natural', or items 23a or 28a-f show iteal Evaciner ment be notified at	d by	3 Widowed 4	Divorced	If Yes, Give Year or Dat			1□Yes 2	IX No	Specify:				Specify:ASI	AN			
5	within 72 hours after death with the Marylar liene. r than "natural", or items 23e or 28e-f show the Medical Executer must be notified at	Completed		5. Decedent's only highest	Education grade completed)		(Give	dent's Usual kind of work	k done d	turina most	t of worki	ng	16b. Kir	nd of Business/	Industry	-		
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Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Fund	aral Service Li	ensee)	22	. Name and	Addres	s of Facility	CHA:	RLES H	IND	S FUNE	RAL S	SERV		
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	Dhysisian '		shock, or heart	failure. List or	nly one cause on ea	ch line.				,,		. respiratory at	1001,		Interval E Onset an	Between		
	Physician ` /Medical		disease or condition resulting in death)			EIMER " r as a consequ		DISEA	SE									
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	be executed ician and burial-transit	Examiner	Cause (Disease or in that initiated events resulting in death) La		C													
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687	ohy:	edical			d													
Вох	death certific e attending p d for use as i	Z.	IF FEMALE: 23b. Was decedent p	pregnant	23c. If yes, outcome			- 11					2	3d. Date of deli	verv			
	death	icia	in the past 12 m 1 Tes 2 1	onths?	4□Pregna	th 2 □ Fetal nt at time of de		Ectopic pre Other (spe						Month	Day	Year		
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Record	has has	Completed										24a. Was autop	sy	24b. Were au prior to c death?	topsy finding ompletion o			
_		e Co	OF Man ages referen	d to modinal								1 Yes	2 No	1 Tes	2□No			
		o B	25. Was case referred examiner? 1 ☐ Yes 2X No.		Hospital:	patient 2 🗆	ER/Outpatien	t 3 DOA	Othe	r		Check onl o		Other (Spec				
		n: T	27. Manner of Death		28a. Date of (Month		28b. Time of		c. Injury	at	-	28d. Describe h			ary)			
Ö	Attending F r death. sctor: After by the funera	atlo	1 Natural 2 Accident	5 Pending investigation	tion	, Day 16ai)	Injury	М	Work 1 □ Y	es 2 □ î	No							
Division	or Attendate death Director:	Certification;	3 🖺 Suicide 4 🖺 Homicide	6 Could no determin	ad 289. Place C	of Injury - At ho g, etc. (Specify	me, farm, str	eet, factory,	office		2	28f. Location (S City or Tow		i Number or Ru	ral Route Nu	imber,		
	Hospital of hours all Euneral D										- 1							
	- 0	edical	29a. Certifier 1: (Check only 2: one)	Medical Ex	Physician: To the bas aminer: On the bas and manne	is of examinat	wledge, death ion and/or in	occurred a restigation, i	t the tim in my op	e, date and inion, deat	d place, a th occurre	and due to the o ad at the time, o	ause(s) a date and l	and manner as place, and due	stated. to the cause	e(s)		
	To the within 2 To the complet	Me	29b. Signature and tit	le of certifier	0	~)		29c.	License	number		12	29d. Date	signed (Month	, Day, Year)			
	1		1/4	Vian	K S.	2-1	ms		D52	261			i i	1/12	InL			
	10)		30. Name and address	s of person wh	no completed cause	death (Item	23a) (Type,	Print)					, ,	113/	00			
	JAC.		ALLAN R					RCLE	SI	LVER	SPI	RING M	D	20906				
	Sta		31. Date filed (Month,	Day, Year)	32. Re	gistrar's Signat	ture											
	negistr	egistrar NOV 1 5 2006 Baren St. Specker																

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#12,16a,20b-c,22,perFH, Co2, Certificate of Death

Reg. No. 38002 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month November 27,2006 JAMES 3:30PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner 707 Maiden Chora Cat 1e Catonsu If Under 1 Year | If Under 24 Hrs timore rwote 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**55**M 2□F Days Hours 220-05-5905 Yrs. Director 17,1920 MARYLAND Usual Residence of Decedent 10b. County 10a State City, Town or Location 10d. Inside City Limits or then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo BAHIMORE on suille UAnd 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21228 Miden Lane Completed by Funeral 12. Was Decedent Ever in U.S. Amped Forces?

1 X Yes State If Yes, Give Year or Dates: 1042–1045 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 22No Specify. Specify: Whi 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Figureering Corp. al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 1211 echNICION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be and Mental I Georg 19a. Informant' me/Relationship (Type, Print) 19b. Mailing Autress (Street and Number or Rural, Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other c f Heelth item 27 i ARSENAUL 01330 Ma, 20a. Method of Disposition Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Baltzimore Department of important: If eny injury or once. ORRAINE Park 22. Name and Address of Facility

VANCY M. WALLACE 21. Signatury of Funeral Service Licensee FUNERAL 34051w. Franklin Street, Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Vascular Dise **Physician** Atherosc le rotic years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the daath certificate be executed attending physicien end for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death P.O. 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 4 Donknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes or Attending Physicien: : Aftar this certifice funeral director, I 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 46 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Oate of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: After completely filled in by the fur death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) ş 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Vovember 28, 2006 Name and address who completed cause of death (Item 23a) (Type, Print) Maiden hoice Lane, Baltimore, MD 21228

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year).

ORIGINAL

32. Pristrar's Signature

6-09054	Please Type or Print in Black Indelible Ink									
Andre Michael A		State of Marylana / Bepartment of Frederical Monte	al Hygiene	2000	2000					
		1- For State Certificate of Death		Reg No. 2006	3800					
Physici		Decedent's Name (First, Middle,Last)	2 Date of De	eath 3 Time	of Death					
Medical Exam	ner	Andre Michael Alexander	Month Novemb	er 28, 2006 Year 014	0 hrs					
Marie and the same of the same		4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of	Death	4c. County of Death						
		4301 Fairfax Road Baltimore		NH						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	24Hrs. 8. Date of B	Birth(MM/DD/YYYY) 9 Birthplace (State or					
Director		1 M 2 F 2 Yrs. Months Days Hours	Min. Jan	11 1985 Foreign Country)	Ma					
		Usual Residence of Decedent	0010	11,1100	74101					
any		10a State 10b. County 10c. City, Town or Location		10d In:	side City Limits					
* .	-	Md N/A Baltimore		1	Yes 2 No					
aryla: 8a-f;	ctc	10e. Street and Number 10f. Zip Code		10g Citizen of What Country?						
72 hours after death with the Maryland n"natural", or items 23a or 28a-f sho al Examiner must be notified at once.	Director	4301 Fair Fax Road 21216		USA						
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ter de		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify		Specify Blac	K					
hours afte	by	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kir	nd of work done	16b Kind of Business/Industry						
2 hou "nat	je	Elementary/Secondary (C-12) College (1-4 or 5+) during most of working life. DO NOT us	se retired)		1.17					
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215-0036 be filed within ntal Hygiene rked other tha ent, the Medic	Be			homas						
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ore, MD 2 sges I and 2 shount of Health and P t: If item 27 is rother traumatic		Tondia Alexander 4301 Fairfax Ro	Baltin	101e						
e, h I and Health item		2Ca Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	2Cc. Location - City or Town, S	tate					
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	edic	UNPENDED #12, perFH, G861, /11/30/06 TT								
68760, certificate be eding physicia	Š	IF FEMALE. 23b. Was decedent pregnant in the 2 Sectopic p	reanancy	23d Date of delivery Month Day	Year					
ox 687 eath certific	cial	past 12 months? 1 Live pirth 2 Fetal death 3 Ecropic p 4 Pregnant at time of death 5 Other (Specify)	rogranoy	Worth Bdy	1 GGI					
Box e death cr	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown								
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Division Spital or Attendi hours after death. meral Director: A	뛸	3 Suicide 6 Could not be determined (Specify) Single Family Home	or Town.	(Street and Number or Rural Route State)	Number, City					
Dospits hours inera		4 M Homicide Cartiflor -		Road, Baltimore, MD						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 bours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the fineral director, page 2 should be detached for use as the buri	cal	Check only Check		• •	s)					
To the within. To the comple	Medical	29 Signature and title of certifier 29 Signature and title of certifier								
	-			29d Date signed (Month, Day,	। ए वा _?					
		(Lacarabella O.C.M.E.		November 28, 2006						
2		39 Name and address of person who completed cause of death (Item 23a)	04004							
		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201							
S Regis	ate	31. Date filed (Month, Day, Year) NOV 3 0 2006 32. Signstrure								
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DHMH 17 Rev 1/2001

State Registrar

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State of Maryland / Department of Health and Mental Hygien 2006

For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician Vovember 27, 2006 4c. County of Death msi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chern rear If Under 24 Hrs. alT re imore 7. Age (In yrs. last birthday Social Security Number If Under 1 Year 9. Birthplace (Sta **Funeral** Hours 217-03-970' 1 □ M 2 X F Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 XYes 2 No Director more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 121 238 Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. In Important: If item 27 is marked other than "naturel", or Item any injury or other treumatic event. Item Medical Entities once. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No þ Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager 18. Mother's Name (Birst, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) miece 20b. Place of Disposition (Name of 21207 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State Mem. Kar 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Serylce License 22. Name and Address of Facility Balto Maizin 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heat draiture. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** O /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical use as the attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 3 Probably 2 No 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ဥ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willies MVELLBA 413 Comma 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov. 23, Day 2006 Mae Abba Cynthia 2330 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 4/28/1949 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 57 Texas 454-92-4414 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Silver Spring Montgomery 1 ☐ Yes 2 No 10f. Zip Code 20904 10g. Citizen of What Country? 10e. Street and Number 1859 Featherwood Street USA 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No Black 1 ☐ Yes 2X No Specify: Specify: 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Federal Gov't Elementary/Secondary (0-12) Executive Assistant 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Ireland Ernest Prevost Mary Louise 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Southwest Drive Silver Spring, Md 20901 A'Ishatu Abba/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 Removal from State Gate of Heaven 12/04/06 Silver Spring, Md 4 Donation 5 Other (Specify PHILIP AD RINALDI FUNERAL SERVICE, P. A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final wn

Physician /Medical Examiner

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Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed by

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any liqury or other traumatic event, the Medical Examiner must be notified at anote.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

-	resulting in death)	aDue to (or as a conseq		<u></u>				
	Sequentially list conditions,	b. Subaracht	noid Hemo	rr	hago			
1	cause. Enter Underlying Cause (Disease or injury	Encephalo						
	that initiated events resulting in death) Last	Due to (or as a conseq						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregning 1 Live birth 2 Feta 4 Pregnant at time of c	l death 3 ☐ Ectopic				23d. Date of deli Month	very Day Year
	Part II. Other significant conditions o	ontributing to death but not res	ulting in the underlyin	g cause	given in Part I.			the cause of death?
						24a. Was an autopsy	24b. Were au	topsy findings availa
						performed 1 Yes 2 ♣	t? death? No 1 ☐ Yes	completion of cause of 2□ No
	25. Was case referred to medical				26. Place of De	performed 1 Yes 2 A eath (Check only one)	i? death? No 1 □ Yes	·
		Hospital: 1 Inpatient 2 □	ER/Outpatient 3□	DOA	Othor	performed 1 Yes 2 eath (Check only one)	No 1 □Yes	2□ No
		28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	28c.	Othor	performed 1 Yes 2 N	No 1 □Yes	2□ No

1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

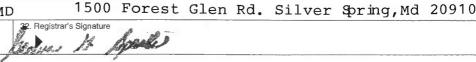
29d. Date signed (Month. Dav. Year)

State Registrar

Medical

Kapoor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Rama

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ma	iryiana /	•	tificate of I	ieaith and N Death	nentai Hy	giene Reg. No2	006	38007
П	Physicia		Decedent's Name (First, Middle)					. •	2. Date of De		2008	3. Time of Death 5:20a M
ije Sprage	/Medic	al≗	Ceola 4a. Facility Name (If not institution	B •			Aust	L1N Location of Death	TT	-	ounty of Death	
}	Examin	er	Bon Secours	_			Baltime				NA	
STATE OF THE PARTY	Funeral Director		5. Social Security Number 406-46-8772		(In yrs. last l 70	birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 03	th Year)	9. Birth	piace (State or Foreign Intry) VA
	land ow t		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	cation				T	10d. Inside City Limits
	a-f sho	ctor	MD NA		Bal	time	ore					1 X]Yes 2 □ No
	vith the	Director	10e. Street and Number				10f. Zip Code	215			en of What Cou	-
	leath v	Funeral	4108 Newton A	12. Was Decedent B	ever in U.S.	13. V		lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No		4. Race - Amer	ican Indian,
5-0036	72 hours after death with the Maryland 'natural", or items 23a or 28a-f show dical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🌠 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	lo		fYes, specify Cuba I⊡Yes ŽÜNo	Specify:	Hican, etc.)		Black, White	
2-0	72 ho "natur dical	Completed	15. Decedent (Specify only highest	's Education it grade completed)	16	Ga. Deced	lent's Usual Occup kind of work done	eation during most of worl d)	king	16b. Kind	d of Business/I	ndustry
121	be filed within 72 ho tal Hygiene. d other than "natun event, the Medical.	dwo	Elementary/Secondary (0-12) 12th grade	College (1-4or 5	+)		se Work			city	of Ba	altimore
מפר	e filed w al Hygier other th vent, th	BeC	17. Father's Name (First, Middle,					18. Mother's Nam		, Maiden S	urname)	
ylar		ToE	Elisha Locket		Τ.			Helen		Oit	T 04-4- 7	- O-1-1
Baltimore, Maryland 2121	E S E		James E. Lock					and Number or Ru ave, B				.215
re,	es 1 and 2 of Health f Item 27 I r other tra		20a. Method of Disposition				sition (Name of natory or other place		Date		ation - City or 1	Fown, State
E	Pages ment of I ant: If Ite		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	Kinc			Barkll/	22/06	Ran	dallst	cown, Md
Ball	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service	Hensee Thomp	Compa	Ma	Name and Addre	ss of Facility sh Ave,	Balti	more	, Mđ	21215
H	- 8. 1		23a. Part1. Enter the disease, or shock, or heart failure. List									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	D	men à						1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as		ce of):	10					
B		eľ	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequenc	ce of):	itr					
	cuted Id ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the charge (Cause (Disease or injury that initiated events	· Hor	7							
90,	icate be executed physician and s the burial-transit	I Ex	resulting in death) Last	Due to (or as	a consequent	ce of):						
68760,	ificate be executed g physician and as the burial-transit	edical		d								
Box (JW/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			∃Ectopic pregnanc	v		23	3d. Date of deli	,
O. B	Attending Physician: The law requires that the death certificate the signed by the attending ector. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown			Other (specify)	,			Month	Day Year
<u>.</u>	that the		Part II. Other significant conditi	ons contributing to death b	ut not resulting	g in the u	nderlying cause giv	ven in Part i.	23e. Did	tobacco us	e contribute to	the cause of death?
Division or Vital Records, P.	equires en sigr ould be	ed by	Drevic				**		1 🗆	Yes 2□]No 3□Pr	obably 4 Unknown
ecc	law renas be	Completed	Denestic						24a. Was	psy	24b. Were au prior to death?	topsy findings available completion of cause of
a H	r: The licate h r, page							00 Pl/D	1□ Yes	ormed? 2 No	1 ☐ Yes	2 No
<u> </u>	ysiciai s certif	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Linemitals	ent 2 ER/	/Outpatier	nt 3 DOA Oth	26. Place of Dea ner: 4□ Nursing H	ome 5 ☐ Res		☐Other (Spec	cify)
n 0	ng Phy fter thi neral (27. Manuar of Death 1 Matural 5 ☐ Pendir	28a. Date of Inju	ry 28	b. Time o Injury	f 28c. Inju Wo		28d. Describe	how injury	occurred	
Sio	ttendli Jeath. Stor: A the fu	catic	2 ☐ Accident investi	gation not be 280 Place of ini	uny - At home	farm str	M 1 Creet, factory, office]Yes 2□No	28f Location	(Street and	Number or Ru	ıral Route Number,
<u>N</u>	affer of Direct of in by	Certification:	4 ☐ Homicide determ	building, et	c. (Specify)	, iditi, ou	oot, lastery, office			wn, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying (Check only one)	ng Physician: To the best Examiner: On the basis of and manner st	f examination	dge, deat and/or in	h occurred at the ti	ime, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) a e, date and	and manner as place, and due	stated. to the cause(s)
	To the Within 2 To the complete	Me	29b. Signature and this of certifie	r			29c. Licens			29d. Date	signed (Monti	h, Day, Year)
}			100	Daycet	Schok	~		00 590	200	11/5	-8/06	
	3		30. Name and address of person	who completed cause of d	leath (Item 23			NT DOG	0 001		Belt 1	ND SISIS
	Sta		31. Date filed (Month, Day, Year,	100 P	ar's Signature			- () (()	1 m		F-71.]	12.12
	Regist	rar	NOV 3 (2006	n K	A	est o					

		-	State of Maryland / Department of Health and Mental Hygiene 0 0 6 3 8 0 0 8 Certificate of Death Reg. No.
	Physicia /Medic	an al	Decedent's Name (First, Middle, Last) RAFAEL ACUILAR—GALINDEZ 11 23 2006 940 PM a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Examin Funeral	Ç.	RALTIMORE REHABILI TATIONS EXTENDED CARE BALTIMORE N/A Social Security Number 6. Sex 157 M 2015 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
	Director		Jouil Residence of Decedent
	e Maryla la-f shov	ctor	MD Baltimore Halethorpe 1□Yes 2√No
	with th	I Dire	0e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 358 Bigley Ave 21227 USA
ယ္	be filed within 72 hours after death with the Maryland nat Hygiene nd other than "naturel", or Itams 23a or 28a-f show event, the Medical Exatrative must be mouthed at	Funeral Director	1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1. Never Married 2. Never Married 3. Never Ma
Maryland 21215-0036	2 hours a maturel', c	ted by	3 Widowed 4 Divorced Year or Dates: 1963 ISYes 2 No Specify: Puerto Rican Specify: Latino 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working
2121	filed within 7 Hygiene. vther than "r ant, The Mad	Completed	Etementary/Secondary (0-12) College (1-4or 5+) 12 Line Man Electric Company
land	should be filed and Mental Hygin marked other matic evant, I	To Be (7. Father's Name (First, Middle, Last) Manuel Aguilar Ana Galindez
Mary	and and is m		19a. Informant's Name/Relationship (Type, Print) Nilda Aguilar/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 358 bigley Ave Baltimore, MD 21227
	00		20a. Method of Disposition 1
Baltimore,	permit. Pag Department Important: f any Injury o		21. Signature of Funeral Service Licensee C. Todd Dring Cremation Society of Maryland, Inc.
			299 Frederick Rd Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate thickness Between Onset and Death
	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death) a. CRRHOSIS END STAGE Due to (or as a consequence of):
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
0,	ate be executed thysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c
68760,	tificate being physicias the bu	ledical	d.
P.O. Box	ath cer ttendir or use	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
	uires that the de n signed by the a lid be detached I	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown
of Vital Records,		Completed	DIABETES MECLITUS 24a. Was an autopsy performed? 1 Yes 20 No 1 Yes 2 No 1 Yes 2 No
Vita	Physician: The this certificate har director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
	ding Phys h. After this funeral dii		27. Manner of Death 1 X Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury Work? 1 Y Natural 5 Pending (Month, Day Year) 28b. Time of Injury 1 Person 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 38b. Time of Injury 3b. Time of Injury 3
Division	l or Attending after death. Diractor: After I in by the fune	Certification:	2 Accident 3 Suicide 6 Could not be determined 4 Homicide Could not be building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th compietely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To th within To th compl	Me	29b. Signature and title of certifier She A Haskini MD D24648 11-23-2006
Ì	140		30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) CHEO A LIACHMIMN 3945 INCH RAVEN BIVD BALTIMORE MN 21218
Ì	Sta Regist		31. Date filed (Month, Day, Year) NOV 3 0 2006 32 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤿 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** :50 A M Marietta Adams 11 27 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Millenium Nursing Home Baltimore (Howard) Ellicott City If Under 24 Hrs. Hours | Min. 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Months Days 45 254-25-1638 1 M 2 M F Yrs 11/17/1961 GA Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d Inside City Limits 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐Yes 2 ▼No Ellicott City MD Howard Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6334 Cedar Lane 21044 LISA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examines 1 XYes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify Specify: African American þ 3 ☐ Widowed 4 X Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th retai1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9881 Broken Lane Pkwy.; Columbia, Maryland 21046 Alisa B. Kobrinetz / Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Cemetery 12/06/2006 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENICEPHALOPATHY Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy perform<u>ed</u>? ospital or Attending Physician; hours after death. uneral Director; After this certifica 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ☐ ER/Outpatient 3□ DOA Certification: To 1 ☐ Yes 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L Hospital 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 29, 2006 00060660 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) NECK RY # 109, BALTIMERE, MD PANKAJ 145 TERPAL 201 BACK RIVER 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 10g per fn 9861 11-30-06 vt.

State of Maryland / Department of Health and Mental Hygiene) 380 L 06 1 - State Registrar Reg. No. Certificate of Death 2 Date of Death 3 Time of Death dent's Name (First, Middle 35 PM Yee **Physician** 005 eve November 243 2006 /Medical 4c. County of Death If not institution, give street and number, Jown, or Location of Death Examiner 6811 CAMFRE BAltimore heran If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In ecurity Number Sex **Funeral** 226-07-1848 Usuel Residence of Decedent 10 M 2□ F rainia Director 10c. City, Townfor Location BAIT; more the Maryland 10d. Inside City-Limits 10b. County 10a, State th and Mental Hygiene. ?7 is marked other than "nature!; or lieme 23a or 28e-1 ehov traumatic event, the Medical Examinar must be notified at 1 ☐Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after deeth Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Eorces? ☐¥es 2 ☐ No Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify Baltimore, Maryland 21215-0036 Black Ď 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tite. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) onstruction 18/Mother's Name irst, Middle, Last) Be 2 permit. Pages 1 end 2 s
Department of Health ar
important; If item 27 is
any injury or other trau BAHMORE Sa 20b. Place of Disposition 20a. Method of Disposition 20c. Location - City or Town, State 1 Defurial 2 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Joseph Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician prostute cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical is certificate has been signed by the attending physidirector, page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetel death 3 Ectopic pregnancy Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ØUnknown Certification: To Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 PNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA this haref Director; After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 PNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 🗌 Homicide To the Hospital caption 24 hours at To the Funaret D completely filled in Hospital 1© Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 0057465 MSHUJAPANSUMO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.S. Rajapall seno 25 Mainst, Reisters town, Suite 200, 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

Hattie Mae Bates

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylan		nt of Health and te of Death		gien 9 0 0 6	38012
		,	Decedent's Name (First, Middle, Las	')			2. Date of De. Month		3. Time of Death
	Physicia /Medic		HATTIE	MAE	BAT	ES	Novemb		6 445 PM
	Examin		4a. Facility Name (If not institution, give		4b. City	, Town, or Location of Dea	th	4c. County of Dea	ith
			134/ G70750 5. Social Security Number 6. Se		E / DC	C/71more/ r 1 Year If Under 24 Hrs		th 9. Bi	rthplace (State or Foreign
	Funeral Director			M 200/F	7 Yrs. Months	Days Hours Min	OCT. O	3,1919	LORIDA
	p.		Usual Residence of Decedent 10a, State 10b, County	100 Cit	y, Town or Location			/	10d, Inside City Limits
	faryla shov	ĕ	10a. State 10b. County	1/2	y, Town or Essention	BAITIN	DE P	1771	1 N Yes 2 No
	28a-f	Director	10e. Street and Number	IA	10f. Z	p Code	THE C	10g. Vitizen of What C	ountry?
	3a or	DI		UCH AVEN	UE	212	18	USA	,
	ema 2	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was Dec	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue	Specify Yes or No into Rican, etc.)	14. Race - Arr Black, Wh	
36	72 hours after death with the Maryland natural; or items 23s or 28s-f show dissi Examinat must be incliffed at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒️No If Yes, Give Year or Dates:	1 ☐ Yes			Specify:	RIDON
Ö	houn tural	ed b	15. Decedent's Ed		16a. Decedent's Us	ual Occupation		16b. Kind of Busines	s/Industry
21215-0036	within 72 ene. then "na	Completed	(Specify only highest gra-	de completed) College (1-4or 5+)	(Give kind of w life. DO NOT	ork done during most of wi use retired)	orking	~	0 . (
21	filed with Hygiene other the	Соп	5 HORADE		LAUNL	DRY ATTE	VDANT	FEDERAL	GOVERNMENT
and	be fill ad oth even	Be	17. Father's Name (First, Middle, Last)	7 40	AMS SR	/	ame (First, Middle	, Maiden Sumame)	1=1
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Ma	and 2 s leelth an m 27 is her trau		STELLA C. LEWI	S (DAUGHTER)	1341	GORSUCH	AVENCE	ALTIHORE .	4021218
re,	of Hee		20a. Method of Disposition		Place of Disposition (National Author)	ame of other place)	Date	20c. Location · City of	r Town, State
imo	Pages nent of I		1. ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		DNATION	AL CEME 12-	02-06	LAUREL	MARYLAND
Baltimore	permit. Pages Depertment of Important: if if any injury or o		21. Signature of Funeral Service Licen	see / / /) ///	22. Name a	and Address of Facility 2	140 N. F	Ulton Aven	ue MC 21217
	₹0 E € a	_	23a. Part1. Enter the disease, or com	N. William	bsepi	H. Brown	Jr. Pune	al Homes &	Approximate
			shock, or heart failure. List only	one cause on each line.			ac or respiratory a	arost,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consec		mmig			days
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V	and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec	manca of):				
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0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurred	
sio	Attending ir daath. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not b		M	1 Yes 2 No	294 Langtion	(Street and Number of	Primi Pouto Numbos
Division	o di ci	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, street, factory)	ory, office		(Street and Number or iwn, State)	nurar Adule Mumber,
tun-6	To the Hospital or within 24 hours afte To the Funeral Director completely filled in h		29a. Certifier 1 Certifying Pr	ysician: To the best of my kn	owledge, death occurre	d at the time, date and pla	ice, and due to the	cause(s) and manner	as stated.
	ne Hoi ne Fui	Medical	(Check only 2 Medical Example)	niner: On the basis of examinand manner stated.	ation and/or investigation	on, in my opinion, death oc	curred at the time	, date and place, and d	ue to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	γ		9c. License number		29d. Date signed (Mo	nth, Day, Year)
	1		/ Culin (/ went		D23076		11/27/02	
	6		30 Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	Tulle R.	e A	celt) Hda	Tl 21211
	7	ate	31. Date filed (Month, Day, Year)	Begistrar's Sign	m 23a) (Type, Print) 3 73	3,10			2121
	Regist		NOV 3 0 2	106 100000	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day}28 Month **Physician** November 2006 Shirley Μ. Brown 2:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilcrest Hospice Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 21 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ^{Year)} 1928 **Funeral** Hours Months Days 1 □ M 2 👿 F 212-26-2664 78 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2746 Yarnall Road 21227 USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Mamed Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Dancer Entertainment other 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 7 is marked of traumatic ever Roland Merkle Unknown Giesler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a (brother) James L. Merkle 6216 N. Orchard Road, Linthicum, MD 21090 Department of Health Important: if item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. Date 30 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) ears **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Furneral Director: After this certificate has been signed by the attending physician and completely filled in by the funneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Yes 2 | No 2 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV 3 0 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

32. Registrar's Stanature

29c. License number

25205

N. Charles St. Rollo Md 2020/

29d. Date signed (Month, Day, Year)

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U6-08836 Tisa Buckner			C+-++			Print in E			11			
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212 212 Ments Ments mark		Oscar Bu1 19a. Informant's Name/Rela	cler tionship (Type	e, Print)		19b. Mailing	Address (Stre	Rose		nfield mber, City or Tow	n, State, Zi	ip Code)
Imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene and If it lieu at 72 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Me. Iteal Examiner must be notified at once.		Rose Green	field			6700	Woodla	nd Roa	ad,Suit	land, Md	. 2	0746
Te, I and I had I had I heal	Γ	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)								20c. Location -	City or To	wn, State
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	ŀ	30. Name and address of pe	erson who con	mpleted cause of	death (Item	23a)						
21		Ana Rubio MD.		Medical Exar		111 Penn S	treet, Baltim	ore, MD 212	201			
Sta	_	31. Date filed (Month, Day,)	ear)	82. Registra	ar's Signati	ure Coasta	,				,	
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KENNETH JOSEPH BOWIE	ision of Vital Records, P.O. B

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30. Name and address of person who completed cause of death (flem 23a) (Type, Print) DAVID ALLEN ST. MARYS HOSPITAL LEONARDTOWN MD 20650 State 31. Date filed (Month, Day, Year) 32. Registran's Signature	0	9 Ph		27. Manner of Death	28a. Date of Injury 28b	. Time of 28c. Injury at Work?	28d. Describe how injury	occurred .
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30. Name and address of person who completed cause of death (flem 23a) (Type, Print) DAVID ALLEN ST. MARYS HOSPITAL LEONARDTOWN MD 20650 State 31. Date filed (Month, Day, Year) 32. Registran's Signature	D	italo Irsafi ralDl						
30. Name and address of person who completed cause of death (flem 23a) (Type, Print) DAVID ALLEN ST. MARYS HOSPITAL LEONARDTOWN MD 20650 State 31. Date filed (Month, Day, Year) 32. Registran's Signature		Hosp 4 hou Fune tely fil	cai	29a. Certifier Check only 2 Medical Exa	miner: On the basis of examination	ga, dauth could at the lime, date and place and/or investigation, in my opinion, death occu-	, and due to the cause(s) rred at the time, date and	and manner as stated. place, and due to the cause(s)
30. Name and address of person who completed cause of death (flem 23a) (Type, Print) DAVID ALLEN ST. MARYS HOSPITAL LEONARDTOWN MD 20650 State 31. Date filed (Month, Day, Year) 32. Registran's Signature		thin 2 the mplet	Med	29b Signature and title of certifier	and manner stated.	29c. License number	29d. Date	e signed (Month, Day, Year)
30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) DAVID ALLEN ST. MARYS HOSPITAL LEONARDTOWN MD 20650 State 31. Date filed (Month, Day, Year) 32. Registran's Signature		Z Z Z S			Call Us		4.1	
DAVID ALLEN ST. MARYS HOSPITAL LEONARDTOWN MD 20650 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		1		20 Name and address of account	completed care of death (from 22)		1	100
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	6	711			The state of the s		50	
					32. Registrar's Signature			

06-09031 Steven Brown Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		Registrar	Certificate o	f Death		Re	g. No. 2	006 3801
Physicia Medical Examin	n/	1 Decedent's Name (First, Middle, Last)				2. Date of Death Month November		3. Time of Death 0837 hrs
neuicai Exaiiiii		Steven Brown 4a. Facility Name (if not institution, give street and number)	T	4b. City, Town, or	r Location of Dea		4c. County of	
		7829 Marlboro Pike, Forestville, MD		Forestville			Prince G	
Funeral	T		yrs. last birthday)	If Under 1 Year Months Day		n		9 Birthplace (State or Foreign
Director		577 94 3333 1\overline{K} M 2 F	45 Yrs			Jan 26	, 1961	Country) Marylan
any	ŀ	Usual Residence of Decedent 10a State	City, Town or Locat	tion			-	10d Inside City Limits
daryland 28a-f show any 1 at once.	5	Maryland Prince George	Fore	estville				1 Yes 2XX No
th the Maryland 23a or 28a-f she notified at once	Director	10e. Street and Number		10f. Zip Code	207/7	10	og. Citizen of Wh United	
hours after death with the Maryland natural", or items 23a or 28a-f sh Examiner must be notified at once		7829 Marlboro Pike 11 Marital Status 12 Was Decedent Ever	in IIS 13 W		20747	Specify Yes or No-		- American Indian, Black,
eath wi	Funeral	1 Never Married 2 Married Armed Forces?	If Y	Yes, specify Cuba			White	
after d	by F.	3 Widowed 4 XX Divorced If Yes, Give Year or Dates.	1	Yes 2 XX	specify:		Specify.	White
136 bin 72 hours afte e than "natural". edical Examiner	edk	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)		nt's Usual Occupa nost of working life			16b Kind of Bu	siness/Industry
36 hin 72 e than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 1	Mecl	nanic			Auto	
5-00 ed wit tygien other	5	17 Father's Name (First, Middle, Last)			18 Mother's Nan	ne (First, Middle, M	laiden Surname	-
	Be	Willard E. Brown	I d Oh Marilia	Address (Otto		n Burton	bar City as Tay	n, State, Zip Code)
and sh	유	19a Informant's Name/Relationship (Type, Print) Terry Nelson (Sister)		,		ningside		
e, M l and 2 Health litem 2		20a Method of Disposition	20b. Place of Dispos crematory or ot	sition (Name of ce		Date		City or Town, State
Baltimore, permit Pages I an Department of Hea Important: If ite		Burial 2 XXCremation 3 Removal from State Department of Other Specify	Lee Crema		ov 30, 2	.006	Clinto	on, MD
Baltimo permit Page Department o Important:	ŀ	21, Sign ture of use all Service Licensee						Inc 6633 01d
	4	a. Part I. Enter the disease, or complications that caused the c	A. Heath Do not enter	lexandri	a Ferry	Road, C1	inton, l	4D 20735 Approximate Interval
Physician /Medical		failure. List only one cause on each line.			.,	, ,		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Acute Coronary Article Due to (or as a consequence)		<u> </u>				
	إ	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequer	nce of):					
	Examiner	cause Enter Underlying Cause (Disease or injury that initiated						
ed	Exar	events resulting in death) Last Due to (or as a consequent	nce of):					
executed an and al - transit	ical	UNPENDED AMENDED			-			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition.	/Medical	IF FEMALE 23c. If yes, outcome of					23d Date of	
ox 68 eath certifu attending for use as t		23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time	- 6 -14-	etal death 3 other (Specify)	Ectopic preg	nancy	Month	Day Year
Box 68 death certif the attending ad for use as	Physician	1 Yes 2 No 9 Unknown 9 Unknown		ittel (opeony)				
that the d	by PI	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause	given in Part I.			bute to the cause of death? Probably 4 Unknown
IS, P quires then signe en signe alld be d	ted t					24a. Was a		Vere autopsy findings available
Division of Vital Records, lat or Attending Physician: The law require 1s after death al Director: After this certificate has been siled in by the funeral director page 2 should be	Completed					autops perfor	sy p med? c	rior to completion of cause of leath?
il Re(in: The rtificate for. page		25. Was case referred to medical		26 Plac	e of Death (Chec	1 Yes 2	2 No 1	Yes 2 No
Vital Fysician:	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatien		Othos		Residence 6	Other, Scene
of \ ug Phy After tl uneral	\vdash	27. Manner of Death 28a Date of Injury	28b. Time of		ury at Work?	28d Describe h	ow injury occurr	ed
sion trendi death ctor: y the f	atio	1 Matural 5 Pending 2 Accident Investigation			Yes 2 No	10011		B. J.B. J. M. When Chi.
Divis	Certification:	3 Suicide 6 Could not be determined (Specify)	· At nome, farm, stre	eet, factory, onice	building, etc.	or Town, St		er or Rural Route Number, City
Di Llospital 4 hours a Funeral I		4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knot (Check only)	owledge, death occu	urred at the time, o	date and place, a	nd due to the caus	e(s) and manner	as started
To the Ho within 24] To the Fu completely	Medical	one) 2 Medical Examiner: On the basis of examina and manner stated						
F 2 F 3	ğ	29b. Signature and title of confiner			ise number			ed (Month, Day, Year)
\sim $<$ $ $		TICON IN		0.0	.M.E. 		November	∠o, ∠uub
7		30 Name and address of person who completed hause of death Susan Hogan MD. Assistant Medical Exam		nn Street, Ba	Itimore, MD 2	21201		
	ate	31. Date filed (Month, Day, Year) 32. Registrar's S		rode				
Regis		NOV 3 0 2006 Bleen	. IN M	Sie Sie				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien $\mathscr{C} \cup \{0\}$ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 10:45PM November Charlie Faith Batten 2.7 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 2 Days 1□M 2♥F Director MD <u>None</u> Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in then "neturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 des 2 No Funeral Director Baltimore MD Baltimore 10g. Cilizen of What Country? 10e. Street and Number 10f. Zip Code 21229 USA 2 S. Woodington Rd. Apt. Gl 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married specify: Black 1 ☐ Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Infant Infant 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown . Pages 1 and 2 should be fill ment of Health and Mental Hent: If item 27 is marked ott jury or other treumetic even Marcella James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 S. Woodon ton Rd. Apt. Gl Baltimore, MD 21229 MARCELLA James (parent) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Importent: If eny injury or once. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of wing, such as cardiae shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Pnysician disease or condition resulting in death) 2hrs. 18min. /Medical Due to r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine -transit requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending | IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) 11/27/06 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 1 🗌 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 0 funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 Natural 5 Pending 2 🗌 No within 24 hours after death. To the Funerel Director: A 1 Yes investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature nd title of certifier 1425566 us 11.27.06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Virma V. Torres,

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division of Vital

Charles St., Ste 309 Baltimore, MD 21204

GBMC 6565 N.

32. Registrar's Signature

M.D.

31. Date filed (Month, Day, Year)

NOV 3 0 2006

State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 12:101 M **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1-28-1924 Birthplace (State or Foreign Country)
 WV 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 X M 2 □ F 233-32-2691 82 Yrs Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or Itame 23a or 28a-f ahow any injury or other traumatic avant, the Madical Exprintmentals be notified at once. 10a State Howard Ellicott City MD 1 Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9692 Oak Hill Drive 21042 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☐ No Specify: 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction Realtor & Builder 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred Hamilton Bennett Edith Mae Massey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9692 Oak Hill Drive, Ellicott City, MD 21042 Mrs. Felicia Bennett/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Crestlawn Gardens 11/28/2006 Marriottsville, MD 5 Other (Specify) 4 Donation 22. Name and Address of Facility Singleton Funeral Home P.A. e of Funeral Service Licensee 21. Signatifi 1 Second Ave SW Glen Burnie, MD 21061 mo1120 ant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SHOCK Physician /Medical Due to (or as a consequence of): Examiner MUNTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit the attending physicien and Due to (or as a consequence of) Box 68760, Physician/Medical es the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. signed by 23e. Did tobacco use contribute to the cause of deatle? Part II. Dither significant conditions contributing to death but not resulting in the underlying cause given in Part I. à page 2 should be O CAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2 ☑ No 2 No 1 Yes To the Hospital or Attanding Physiclan: within 24 hours after death. To the Funeral Director: After this certifica : After this certification, funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **N**O patient 2 ER/Outpatient 3 □ DOA 27. Manner of Death 1 Thatural 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Yes 2 No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOV,27 KENNETH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 ARMOI SUITE BALTIMOR 9 32. egistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygien 2006 38019 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 25 2006 9:00 P.M. **Physician** Bellas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BHRNIE WAKHNETIN MEDICAL COUNTY ANNE ALUNDEL GLEN Baltimat If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral X** M 2□ F Months Director 027-30-3540 March 19,1915 MA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or itame 23a or 28e-f ahow other traumatic avant. The Medical Examinar must be notified at 1 ☐ Yes 2X No Completed by Funeral Director Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8327 New Cut Road 21144 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Military Government 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname s 1 and 2 should be fi f Health and Mental H itam 27 is marked otl Be James William Bellas ဥ UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if itam 27 i Mr. Robert Bellas/ Son 8327 NEw Cut Road Severn MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) **Itimore** Dec 2, 20a. Method of Disposition 20c. Location - City or Town, State 0 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 4 □ Donation -5 ₺ Other (Specify) Entombment Cedar Hill Cemetery 2006 Brooklyn Park MD 21. Signature Of uporal Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. Second Avenue SW Glen Burnie, MD 21061 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** W Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy cate has been signed by the atterpage 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 20 No certificate has 1 Yes funeral director 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 1 Inpatient Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 5 Pending death. 1 Yes 2 No investigation the Diractor 6 Could not be determined 3 Suicide 28e. Place ol Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Direct Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a to 31. Date liled (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ariend 1 tem 15 per fh 8861 11-30-06 vt State of Maryland / Department of Health and Mental Hygiene 2 0 6

38020 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 27, 2006 **Physician** 6:40 A BURGESS SOLOMON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner COLUMBIA HOWARD VANTAGE HOUSE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Days Hours Min. 05/17/1915 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1₩ 2□F 91 Yrs NY 099-05-0376 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral, or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director FL PALM BEACH DELRAY BEACH 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6356 KINGSGATE CIRCLE 33484 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married WHITE 1 ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 Specify þ If Yes, Give Year or Dates: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+ HEATING & AIR COND. CONTRACTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NEWMAN BERGER ROSE SIMON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SCOTT BURGESS / SON 710 WHITE SWAN DRIVE - ARNOLD, MD 21012 20a. Method of Disposition

1 \(\Delta \) Burial 2 \(\Delta \) Cremation 3 \(\Delta \) Removal from State

4 \(\Delta \) Donation 5 \(\Delta \) Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other placeGARDENS 20c. Location - City or Town, State ETERNAL LIGHT MEMORIAL 11/28/06 BOYNTON BEACH, FL any injury 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** DEBILITY resulting in death) /Medical Due to (or as a consequence of): Examiner DEMENTIA Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto for as a consequence of: Examiner death certificate be executed use as the burial-transit and Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 ☐ Yes 2 X No Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖔 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation I or Attend after death Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of bertifier D53987 NOVEMBER 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21201 300 ARMORY PLACE, SUITE SUITE 39 KENNETH GEH, M.D.

Registrar

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2006 38021 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Melvin W. Burrell 11:10 A^M 11 26 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Sinai Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1X M 2□ F 74 Director 218-28-6107 12/05/1932 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1012 N. Payson Street 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 ☐ No Specify. African American Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th repairman radio station 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Burrell Magdeline Moyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avon Burrell / Brother 1012 N. Payson Street; Baltimore, Maryland 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/02/2006 Mount Zion Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. Tunela Vones 638 N. Gilmor Street; Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive heart /Medical Due to (or as a consequence of): Examiner Orongr Vascular disease Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Chronic Obs as the burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical Essenter 1 Hupertensiem IF FEMALE been signed by the attendin should be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 Yes 1 ☐ Yes 2 ☑ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 X ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Injury at Work? 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MIORPENSI, mo D30115 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2600 LIBERTY AYC Balt, hio kpehai, mo HaTS 31. Date filed (Month, Day, Year) 32. Regiarar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 0 6 38022 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 1507 M Year Vorman gwthorne 27 Caward NOV 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospital Balhmore Suchmore Gile sinal 0 **Funeral** Social Security Number 10M 20F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 219-50-0065 Director Yrs. 23.1946 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location : If item 27 is marked other than "naturel", or items 23a or 28a-f show or other treumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Md Baltimore Director N 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6208 21215 AVE USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 Yes 2 No Š Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 10th Yechanica ENGINEER permit Pages 1 and 2 should be filed v Department of Heelth and Mental Hygie Importent: If Item 27 is marked other t ommercial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman E. Lawthorne Alexander Vulia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore timore, 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Burial 2 Cremation 3 Removal from State Garrison Forest Cem. 4 ☐ Donation 5 ☐ Other (Specify) 12/4/06 Owings Mills Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funcial Home Lerry Danis 5240 Presterstown head Baltimore Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastand Physician Esiphaeus CA near /Medical Due to (or as a consequence of): Examiner month niva tou Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of); burial-transit Due to (or as a consequence of): for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 28 No 25. Was case referred to medical 26. Place of Death | Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerei C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and normal settated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kes- 000 30. Name and address of person who completed cause of death (Item 3a) (Type, Print) 3 hhishina Enmany Sinai 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State Registrar NOV 3 0 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registra/Amend item#10e, 19b, per FH, G861, 10/201/106/17 of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** November 26 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JUN K 405 ortal If Under 24 Hrs. Social Security Number 6. Se Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday **Funeral** Days Hours **™** M 2□F 22 Director 04 16 84 MD 215-06-1225 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location la or 28a-f show t be notified at 10a State 10b. County 10d. Inside City Limits 1 X Yes 2 ☐ No Baltimore Director NA MD 10e. Street and Number
Barrett
Barett 10f. Zip Code 10g. Citizen of What Country? 21207 U.S.A. Road "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation ?7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled llth grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Yvonne Miles 2 Clifton_Church 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1521 Barrett Road, Baltimore, Md 2120 19a. Informant's Name/Relationship (Type. Print) 21207 Yvonne Ellis-Mother other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. MBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 12/01/06 Randallstown, Md 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md <u> 21215</u> 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** reumania days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** rciency Vivus ruman Im Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Box 68760, Netabol Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a P.O. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? 1 ☐ Yes 2 X No certificate 1 Yes 2 ☐ No Division or Vital Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this within 24 hours after death.
To the Funeral Director. 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 2 Accident 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No | Director: A 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide TSC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

Ictaria

600 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mobiler

mossie

North Wolfe

29c. License number

29d. Date signed (Month, Day, Year)

06-09009 Stephen Curtis

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 2006 38025 1. For State Certificate of Death Reg. No Registrar Physician/ Decedent's Name (First, Middle Last) 2. Date of Death Month Day November 26, 2006 **Medical Examiner** Stephen Curtis Anthony 1051 hrs 4a Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 4c County of Death 5528 Belle Avenue **Baltimore City** 5. Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Months Days Director Hours 05 31 66 216-90-5388 1 X M 2 40 Country) MD Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits s 23a or 28a-f show e notified at once. Baltimore 28a-f show MD NA 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 5528 Belle Ave 21215 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must he or items Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White, etc. Yes 2X No Pages 1 and 2 should be filed within 72 hours after of mont of Health and Mental Hygiene and I fleath and Mental Hygiene and I fleat 27 is marked other than "natural", or other trannatic event, the Medical Examiner in Black 3 Widowed 4 Divorced If Yes Give Year 1 Yes 2x No specify: Specify 2 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 10th grade Laborer Construction 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Ernest Curtis Sheria Boston 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Real to, Md 21215 19a Informant's Name/Relationship (Type, Print) ٩ Shirley A. Miller-Sister 20a Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) 1X Burial 2 Cremation 3 Removal from State Important: injury or ot 12/4/06 Baltimore, Md Carmel Donation 5 Other Specify: 22. Name and Address of Facility
March F/H West
4300 Wabash ave, ature of Funeral Service Licenses Baltimore, 21215 ims 23a. Pen I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line /Medical Between Onset and Death Immediate Cause (Final disease a Pneumonia Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and Physician/Medical g physician a the burial -X UNPENDED AMENDED #23a,27.perME. g862. 12/21/06 TT Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Year Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions Records, P.O. contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed been 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 V No Yes 25. Was case referred to medical To the Hospital or Attending Physician: 26 Place of Death (Check only one Division of Vital Other₄ this Inpatient ER/Outpatient 3 DOA No Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes After 28b. Time of Injury Manner of Death 28a. Date of Injury (Month, Day,Year 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Pending Yes 2 No Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical within 2 To the 1 one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier of 29c License number 29d Date signed (Month, Day, Year) O.C.M.E. November 27, 2006 Une. 30 Name and address of person who completed cause of death (Item 23a) Ana Rubio MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Many 30 30 2006 gistrar's Signatu

State Registrar

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				ate 31. Date filed (Month, Day, Year) 2. Registrar's Signature												_	

DHMH 17 Rev 1/2001

06-08936 John Paul Dowery

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No. 2006 3802													
Physicia		Decedent's Name (First, Middle)	e,Last)							Date of Dea Month		Year		. Time of Death	
ledical Examir	ner	John		Paul			Dowery			Month Novembe				2310 hrs	
		4a. Facility Name (if not institution		ımber)		41	c. City, Town, or	Location of	Death			ounty of NA	Death		
		John Hopkins Hospita	1				Baltimore								
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birth	nday)	If Under 1 Yea Months Days		24Hrs. Min.	8. Date of Bi	rth (MM/DD		Birthp Foreign	place (State or	
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		Usual Residence of Decedent													
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how how	_	M -3	NA		R:	altin	ore						1	Yes 2	No
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ter de		3 Widowed 4 Div	1 Yes	2 X No		1	Yes 2 No	specify:			Sp	ecify:	Bla	ck	
irs afi ural	화	15. Decedent's Education (Spe	or Dates:		16a. C	Decedent'	s Usual Occupa	tion (Give k	ind of wo	rk done	16b. Kind	d of Busi	iness/Inc	lustry	- 1
2 hou	etec.	Elementary/Secondary (0-12)	College (1-4 or 5+)	۰ ا	luring mo	st of working life	. DO NOT (use retired	d)	T				
21215-0036 und be filed within 72 Mental Hygiene, marked other than ° c event, the Medical	Completed	10th grade			1	Maint	tenance				Uni	Lver	sity	of Md.	
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215 e file tal H ked c	Be (John	Pat	ul	Do	wery	, Sr.	Sa	arah			M	yers		
21. Duld bould b	P	19a. Informant's Name/Relations					Address (Stree								
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland thth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f she aumaite event, the Medical Examiner must be notified at once		Sarah McKes	son I	Mother		2416	Loch Ra	iven F	Rd.,	Balti				.218	
1	- 1	20a. Method of Disposition				f Disposit	tion (Name of ce	metery,		Date	20c. Loc	ation - (City or To	own, State	
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Balt permit. Departi Importi injury	- 1	Bruga Melkin 1101 E. North A									timore	e, M	ið.	21202	
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/Medical		failure. List only one cause	Maultinla C	unshot Wor	ınds									Between Onset Death	and
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)		a consequence									\neg		
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P.O. Box 687 s that the death certific gned by the attending is e detached for use as the	by P	Part II. Other significant condi	tions contributing	to death but not	resulting	g in the u	nderlying cause	given in Pa	ırt I.		_	_	_	e cause of death	
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ige spi		4 Homicide 29a. Certifier 1 Certifying	Physician: To the b			ath occur	red at the time	date and pla							
To the Howithin 24 P. To the Function	Medical		aminer: On the basi	s of examination	and/or i	investigat	ion, in my opinio	n, death oc	curred at	the time, dat	e and place	a, and di	ue to the	cause(s)	
To the within: To the comple	Meo	29b. Signature and title of certif	and manner ier	stated			29c. Licen	se number			29d. Da	ate signe	ed (Mont	th, Day, Year)	
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7	6 3	30. Name and address of period		use of destriction Medical Exa		111	Penn Street	Baltimo	re MD	21201					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year F DEGRAFFENREID /Medical NOVEMBER 24 2006 7:18 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Months Days Hours Min Director Usual Residence 36 456 dent 73 Mar 27, 1933 So. Carolina permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "maryland any Injury or other than" 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No Director Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 3866 McDowell Lane U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced 1951 X Black Completed 1958a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **B** Green Company Warehouseman 17. Father's Nan 2(First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Unknown Mamie Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

3866 McDowell Lane Baltimore, Maryland 21227

20b. Place of Disposition (Name of Date Date 20c. Location - City or Town, State Marion Brown Daughter 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 Sonation 5 ☐ Other (Specify) 12/01/06 Lansdowne Maryland Mt. Zion Cemetery 22. Name and Address of Facility Signature of Funeral Service License 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mol 300 Exptain Riace. Baltimorie, Md. 21217 shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SOPSIN **Physician** /Medical as a consequence of): Examiner BRIRATION PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 🗌 No 3 Probably 4 ☐Unknowr Completed peen 24b. Were autopsy findings available prior to completion of cause of death? autopsy page performed certificate COPD 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 NO 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3□ Suicide Płace of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 Homicide To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) November 24, 2006

Registrar

State

30. Namé

31. Date filed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

Lit Mokan VERMA - Frederick Memorial Host

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 25 11 2006 5:10p. M Dorothy Elizabeth Dais /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NA Baltimore Mariner Care Roland Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05 11 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 218-10-7224 Director 92 MD Usual Residence of Decedent Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☑ Yes 2 ☐ No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 2417 Shirley Ave U.S.A. death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant if item 27 is marked other than "natural", or iten ury or other traumatic event, the Medical Examinea ury or other traumatic event, the Medical Examinea. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Benefits Claims Examiner Social Security Adm 12th grade 2vrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lelia Johnson ျ Raymond Wheatley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2513 Park Heights Terrace, Balto, Md 21215 Muriel Rice-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Crematory Inc 11/29/06 Baltimore, Md 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Dimentia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner he lay requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, physician a s the burial-Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the ar 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ thknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an s certificare has the irector, page 2 st autopsy performed or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 P 27. Manner of Death 28a. Date of Injury (Month, Day 28h Time of 28d. Describe how injury occurred Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death.

Director: / 2 Accident 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

HASHMI MD, 821 N. EUTAWST Shite 300 BALTIMORE MD 21201 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WD

29c. License number

D 31464

29d. Date signed (Month, Day, Year)

Decoderly Name (Frex, Modific, Last) Id D 'Angelo 2. Date of Death November 2, vest November 2, 2006 8,340 PM Right Recommendation Reco				For State Registrar	State of	Marylan		artment of H Hificate of L		lental Hy	giene, Reg. No.	2006	38030		
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May Section Committee		Funeral		4						(Month, Da	ay, Year)		thplace (State or Foreign ountry)		
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State of Maryland / Department of Health and Mental Hygien 38031 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 25, 2006 **DESSER** NAOMI 11:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS CHERRYWOOD REISTERSTOWN BALTIMORE | Hours | Min. | 8. Date of Birth | Hours | Min. | 08/2//1922 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days 1□M 2**∏**F 216-12-8575 84 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event. The Madical Exemina-10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2414 TANEY ROAD 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Completed by Specify: WHITE Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALESPERSON PACKAGE LIOUOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HARRY DAVIS MARGARET ပ SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, DAVID DESSER / SON 12528 VALLEY PINES DRIVE - REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH JACOB CEMETERY 11/29/2006 FINKSBURG, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that i Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. been signed by the a should be detached 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CA 100651) 1 Tes 3 Probably 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 No 1 Yes : After this certifical funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ro the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of 29d. Date signed (Month, Day, Year) completed/cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 3 0 Registrar

			1 - For State Registrar	State of Maryland		nt of Health and N te of Death	Mental Hygier		38032
1	Dhysi	oion	Decedent's Name (First, Middle, Last)		r		2. Date of Death	Day Year	3. Time of Death
	Physic /Med	lical	AUDREV 4a. Facility Name (If not institution, give s	JOYCE	E WEL	Town, or Location of Death	Novembe		815/4 M
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	Funera		5. Social Security Number 6. Sex		ast birthday) If Unde Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye		lace (State or Foreign
	Directo	r	Usual Residence of Decedent		/ 113.		OCT, 30, 1	797 MA	RYLAND
	arylan show	-	10a. State 10b. County	10c. City	, Town or Location	- 1 2 0		10	0d. tnside City Limits 1 ☐ Yes 2 🗷 No
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61	er dea items	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☑ No	S. 13. Was Dece If Yes, spe	dent of Hispanic Origin? (Sp orfy Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White,	
X	13-00.30 72 hours after death with the Marylan "natural; or items 23a or 28a-f show edical Examinar must be political at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	22 No Specify:		Specify: BLI	4CK
6	ILZ I 3-UU30 within 72 hours after death with the Maryland ene. than "natural" or items 23a or 28a-f show to Medical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation a completed)	16a. Decedent's Usu (Give kind of wo life. DO NOT u	ork done during most of work	sing 16b	. Kind of Business/Inc	lustry
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J.		P	HERBERT 19a, Informant's Name/Relationship (Ty)	L, KE	19b Mailing Address	S (Street and Number or Rui	SICE ral Route Number, Cir	OVER Town State Zin	Code)
	< = ~ =		ZINA M. EWELL-SPE	EARS (DAUGHTER)	1719 W.	LEXINGTON	ST. BAG	LTIHORE M.	0.21223
			20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ R	20b. Pi	ace of Disposition (Na emetery, crematory or	me of other place)		Location - City or To	
	baltimo permit. Page Depertment of important: If any injury or		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	WE	STERN STA	R (EME - a		PTONSVILL	E, MD,
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ć	VISION OF VITAL MECORDS, P.O. BOX of Attending Physician: The law requires that the death certific rideath. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ØNo	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic p			23d. Date of delive Month	Day Year
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1	The lav	Com					autopsy performed 1 ☐ Yes 2 🔏	? death?	
	r VICAL Pysician: Th ysician: Th s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	ER/Outpatient 3 Di	Other	th (Check only one)	e 6 ☐Other (Specify	4
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č	S effer all or A	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify)	y, office	City or Town, St		riodia reambar,
	UVISIO To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the to	Medical (29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occurred ion and/or investigation	at the time, date and place, n, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as standard place, and due to	ated. the cause(s)
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	\cap		30 Name and address of parson who are	moleted cause of death (fee	23a) (Type Print)	10043934	MO	ivember 2	0,2006
	<i>T</i>		30 Name and address of person who co	1.0 .2245	ST. PAU	L PLACE	BALTIN	bre ma	8,2006
	S Regis	tate trar	31. Date filed (Month, Day, Year) NOV 3 0 201	32 Registrar's Signal	pools				

			For State Registrar	State of N	Maryland / Depa	artment of H		lental Hygier	2000	38033
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	/Medi Examir	cal	4a. Facility Name (If not institution, s	rive street and number	TEIN	4b. City, Town, or	Location of Death	MONEMBER	4c. County of Death	V. J
			NORTHWEST HOSPI			RANDALI	LSTOWN If Under 24 Hrs.	0.0.48:4	BALTIMOR	
h	Funeral Director		5. Social Security Number 219–40–1839	Sex 1 M 2 F 7.7	Age (In yrs. last birthday) 63 Yrs.	Months Days	Hours Min.	8. Date of Birth 12/24/19	42 9. Birth	place (State or Foreign intry) MD
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-fah	ctor	MD BALT	IMORE	BAL	ΓIMORE				1 ☐ Yes 2 X No
	with th	Funeral Director	10e. Street and Number 8831 ORCHARD RO	IAD		10f. Zip Code	21208	10g.	Citizen of What Cou	untry? USA
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36	within 72 hours after death with the Maryland ene. than "natural", or Itama 23a or 28a-f ahow ha Madical Examinar maat ba noilliad at	by Fu	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced		() No	1 ☐ Yes 2 X No	Specify:	ricali, etc.)	Black, White	WHITE
2-0	72 hou	eted	15. Decedent's (Specify only highest)	Education grade completed)	(Give	dent's Usual Occupa	during most of work	ing 16b.	. Kind of Business/Ir	ndustry
21215-0036	giene.	Completed	Elementary/Secondary (0-12)	College (1-4c	r5+)	DO NOT use retired RETARY	"	Mi	EDICAL	
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Balt	permit. Pages 1 end 2 Department of Health a Important: If Item 27 it any Injury or other tra		21. Signature of Funeral Service Lice	ensee (it	11.	2. Name and Addres		L LEVINSOI ROAD - PI		
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V	uted d ansit	Examine	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	(0)	as a consequence of):	ARTER	Y DIS	SEASE		
8760,	icate be executed physicien and the burial-transit	ai Ex	resulting in death) Last	Due to (or a	as a consequence of)!					
9	tificate ng phys as the	Medicai		d				-		
Вох	thet the death certifi ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliving Month	rery Day Year
P.O.	et the c 1 by the stached	Physi	1 □ Yes 2 MNo 9 □ Unknown		9☐ Unknown contributing to death but not resulting in the underlying cause given in Part I.					
Records,	The law requires thet the death certificate hes been signed by the attending I agge 2 should be detached for use as	Completed by	Part II. Other significant condition:	contributing to death	t but not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobacc	o use contribute to 2 □ No 3 □ Pro	
leco	he law re hes bee ge 2 sho	nplet						24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
		e Cor	25. Was case referred to medical				00 Bloom 4 Book	performed		2 X No
of Vital	Physiclan: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 Inpa	atient 2 ER/Outpatier	nt 3 DOA Othe	90	n <i>(Check only one)</i> me 5□ Residence	6 ☐Other (Speci	fy)
o uo	After After fune	tion;	27. Manner of Death 1 K Natural 5 ☐ Pending 2 ☐ Accident investigal	28a. Date of In (Month, I	njury 28b. Time o Day Year) Injury	Work	/ at k? Yes 2 □ No	28d. Describe how in	njury occurred	
Division	or Attendil after death. Director: A in by the fu	Certification:	3 Suicide 6 Could no 4 Homicide determine	be 28e. Place of	Injury - At home, farm, st etc. (Specify)	reet, factory, office		28f. Location (Street City or Town, St	and Number or Rur ate)	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funersi Director: After th completely filled in by the funeral	edical Co	29a. Certifier 178 Certifying (Check only one) 2 Medical Ex	aminer: On the basis	st of my knowledge, deat	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the cause ed at the time, date a	e(s) and manner as and place, and due to	stated.
	ro tha vithin 2 ro tha comple	Med	29b. Signature and title of certifien	and manner		29c. License	e number	29d. I	Date signed (Month,	Day Year)
	> - 0		> Jaginda P	mehl	ia m.o	DH	1410	1	vember 9	11.
	3		30. Name and address of person wh				NOER.	MEHT		00
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regi	Strar's Signature	IN ICAI	NOMUST	omn D	10 211	`5'5 ·
	Regist	rar	NOV 3	2008	sever it to	booke				

06-08894 Breanna Edwards

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 38034

	1- For State Registrar	Certificate of Death	Reg. No. 2000 0000
Physician/ ledical Examine	Decedent's Name (Eirst, Middle,Last)	Edwards	2. Date of Death Month Day November 22, 2006 3. Time of Death 1739 hrs
	4a. Facility Name (if not institution, give street and numb St. Agnes Hospital	er) 4b. City, Town, or Location of D Baltimore	Death 4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7.	Age (in yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours Yrs.	Win. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) M. d.
Maryland 28a-f show any 1.at once. Pector	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location Baltmor	10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f sh tifted at once	10e. Street and Number 3340 W. Cafo	10f. Zip Code 2/23	10g. Citizen of What Country?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland n and Mental Hyggie eight. To Tis marked other than "natural", or items 23a or 28a-fishe matic event, the Medical Examiner must be notified at once To Be Compuleted by Funeral Director		If Yes, specify Cuban, Mexican, Portion 1 Yes 2 No specify:	werto Rican, etc.) White, etc. Specify:
5-0036 led within 72 hours af Hygiene. I other than "natural the Medical Examin Completed by	Elementary/Secondary (0-12) College (1-4	or 5+) during most of working life. DO NOT use	e retired) A A
21215-00 uld be filed wit Mental Hygien marked other c event, the M	Gancy Edwar	ds Cata	Name (First, Middle, Malden Surname) Ewba Ballard
2 E E E	I-lancy Edwards-		Pror Rural Route Number, City or Town, State, Zip Code) And Bacto, md, 21229 Date 20c, Location - City or Town, State
다 유 유 교	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other Specific	State crematory or other place) Metro (rematoring)	11/30/2016 Catonsville, md.
Baltimo	21. Signal ye of Funeral Service Licensee	22. Name and Address of Facility Oary P. marc	270 Fred HILTON Pass In Funeral Home Butto, ma, 212:29
Physician Medical Examiner	failuré. List only one cause on each line. Imm. Late Cause (Final disease a. Sudden	sed the death. Do not enter the mode of dying, such as card unexplained death in intency. Chi	diac or respiratory arrest, shock, or heart i.l.dhood Approximate Interval Between Onset and Death
<i>)</i>	or condition resulting in death) Due to (or as a condition sequentially list conditions,		
ed nsit Framiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co		
n and I - transit	Q.	#23a.perME. G866. 4/3/07 TT 23a.27.28a=f. perME. 9863 1/24/07	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transification: To Be Completed by Dhusician/Modical Expedition 1.	## ## ## ## ## ## ## ## ## ## ## ## ##	come of pregnancy 1 2 Fetal death 3 Ectopic pr 1 at time of death 5 Other (Specify)	23d. Date of delivery
P.O. Box 6 res that the death ce signed by the attend be detached for use the detached for use the Diversity of the Diversity		eath but not resulting in the underlying cause given in Part l	1. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law require stafer death. all Director: After this certificate has been six led in by the funeral director, page 2 should by the fifter the Commission. To Re Commission and the contraction of the contraction of the contraction of the commission of the commis			24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 24b. Were autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No
Vital R ysician: 1 his certific director, p	25. Was case referred to medical	26.Place of Death (C	heck only one)
Physic r this c	Yes 2 No 1 Inp		Nursing Home 5 Residence 6 Other:
ion of tending Pheath. for: After the funeral		Injury 28b. Time of Injury 28c. Injury at Work? 22/2006 Fnd. 4:40 pm 1 Yes 2 X N	ulkilowii
Division or pital or Attending ours after death. Beral Director: After filled in by the fune		of Injury - At home, farm, street, factory, office building, etc. House	28f. Location (Street and Number or Rural Route Number, City or Town, State) 3340 W. Caton Avenue Baltimore, MD
To the Hosp within 24 hou To the Fune completely fi		of my knowledge, death occurred at the time, date and place examination and/or investigation, in my opinion, death occu ed	e, and due to the cause(s) and manner as started. Irred at the time, date and place, and due to the cause(s)
FSFS	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) November 23, 2006
	30. Nan and ad 15 s of person with completed cause Pamela E. Southall, MD Assistant M		
Stat Registra	te 31. Date filed (Month, Day, Year) 32. R	strar's Signature	

7		•	- State Amend item#10e,	State of Maryla perFH, g861, 1	nd / Depa 1/30/06 T	artment of H	lealth and Death	Mental Hy	giene Reg. No 20	06 3803	35
			1. Decedent's Name (First, Middle, Last)				-	2. Date of De Month		3. Time of Deat	
	Physicia /Medic	_	LEAH P. FRISB	Y		<u> </u>			25 20	086 9:57	PM
)	Examin		4a. Eacility Name (If not institution, give : Franklin Souar		4b. City, Town, o	tale		Bal-	of Death Himore		
	Funeral Director			7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Mi		3/1917	9. Birthplace (State or Fore Country) MARYLAND	eign
	land		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Lin	nits
	death with the Maryland me 23a or 28a-f show r must be notified at	to	MD BALTIM	ORE	ESSE	Х				1 ☐ Yes 2 ☐	No
	th the	Director	10e. Street and Number		328	10f. Zip Code			10g. Citizen of V	What Country?	
	23a (23a (23a (23a (23a (23a (23a (23a (1900 GROVE MANO	R DR., APT	. 308	2	1221		USA		
	er de:	Funeral		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Rac Blac	e - American Indian, ck, White, etc.	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify	BLACK	
1215-0036	be filed within 72 hours after death with the Marylan deathly gione. I all typione. I all typione. I all typione. I all the Marylan Examinar must be notified at event, it a Marylan Examinar must be notified at	ted	15. Decedent's Edu	cation		dent's Usual Occup		4.	16b. Kind of Bi	usiness/Industry	
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire		vorking		MORE CITY	
2	filed wi Hygien other th	Co	12 YEARS		DI	ETICIAN		:		IC SCHOOLS	
⊆		Be	17. Father's Name (First, Middle, Last) EDWARD PECK,	SR				lame <i>(First, Middl</i> e) HERINE I		ne)	
Ž	d 2 should be th and Mental 7 is marked of traumatic ev	မ	19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street				State, Zip Code) 212	21
	123g		SEAN A. COLB		~ BT					State, Zip Code) 212 B, ESSEX, M	
altimore,	of Heelt fitem 2 r other		20a. Method of Disposition		Place of Dispo	sition (Name of matory or other pla	I	Date		City or Town, State	
Ē			1XX virial 2 □ Cremation 3 □ P 4 □ Donation 5 □ Other (Specify)	emoval from State	MOODLA	WN CEME	TERY 1	1/30/06	BALTIM	MORE CO., M	D
Balt	permit. Pag Depertment Important: eny injury o		21. Signature of Feneral Service License	90						HOME 2120 BALTIMORE,	
			23a. Party. Enter the disease, or complete the complete or heart failure. List only or	cations that caused the de	ath. not ent	ter the mode of dyi	ng, such as card	iac or respiratory a	rrest,	Approximate Interval 8etween	1
Ph	Physician ¹		Immediate Cause (Final disease or condition	alphall				rain and		1 Occasional Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):							
	LAUMMICI	-	Sequentially list conditions,	Due to (or as a conse	editence of:						
	nsit A di	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	squerice or,						
Ć,	s be executed sicien and control fransit	Exa	that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
8760	icate be executed physicien and s the burial-transi	dlcal	C.								
99	entifica ing ph e as ti	Med	IF FEMALE:								
Вох	death certific attending p	lan/	in the past 12 months?	23c. If yes, outcome of preg 1☐Live birth 2☐Fe 4☐Pregnant at time of	etal death 3	Ectopic pregnanc	у			ite of delivery onth Day Year	
o.	The law requires that the death certific sie has been signed by the atlending p page 2 should be deteched for use as	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown	rdeam 5	Other (specify) _					
٥.	signed by	by Ph	Part II. Dther significant conditions con	ntributing to death but not re	esulting in the u	nderlying cause gr	ven in Part I.	23e. Did t	obacco use cont	tribute to the cause of death	?
Division of Vital Records,	w requires been sign should be							_ 10	Yes 2 No	3 Probably 4 Unkno	own
000	ie law requ has been je 2 should	Completed						24a. Was	an 24b.	Were autopsy findings available prior to completion of cause	able
č	ysician: The I is certificete ha director, page	EoC						perfo	ormed?	death? 1 ☐ Yes 2 ☐ No	OI .
/ita	ician: Th certificete rector, pag	Be (25. Was case referred to medical examiner?					Death (Check only	one)		
_	Physician: r this certifice ral director, p	7	1 Yes 2 No	lospital: 1 Inpatient 2	☐ ER/Outpatier	IL 3 DOA		g Home 5 ☐ Resi			
5	ding h. After funer	tlon	1 Natural 5 ☐ Pending	(Month, Day Year)	28b. Time o Injury	Wo	ryat rk?]Yes 2∐No	200. Describe	how injury occur	red	
/isi	Attending it death.	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, str		, 100 2 2 110			ber or Rural Route Number,	
ă	s effer if Dire	Certification:	4 Homicide determined	building, etc. (Spe	cify)	******		City or To	wn, State)		
	To the Hospital or Attending Ph within 24 hours eiter death. To the Fuheral Director: Affer th completely filled in by the funeral	edical		sician: To the best of my k iner: On the basis of exami and manner stated.							
	within 24	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	ed (Month, Day, Year)	
	1					Doos	503 Y		11/2	17/06	
	h	N.	30. Name and domess of person who ca	ompleted cause of death (II	tem 23a) (Type,	Print)	1.1.	1	\	2 11	
	J		Dr. Jacques -	K. L'unawo	my 91	ovo tra	nklin.	fquare i	Irive 1	salto, MD 2	123
	Sta	te ar	31. Date filed (Month, Day, Year)	32. Registrar's Sig	mature	SAEL!		V			

			1 - For State Registrar	State of Mary		artment of I			giene 2 (006	38036
			Decedent's Name (First, Middle, La	st)				2. Date of Dea			3. Time of Death
	Physici		Azalee	C.		Fore	eman	Month	Day	Year	11:04th
	/Medi Examir		4a. Facility Name (If not institution, gir			4b. City, Town, o	or Location of Dea	Mounter th	4c. Count	2 606 ty of Death	11.04
			Sinai hospital	of Balling	2	Rathinan	e citu				
	Funeral		5. Social Security Number 6.	Sex 7. Age (Ir	yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth) Vear	9. Birthi	place (State or Foreign
	Director		246-12-7486	I □ M 2 🛣 F 8	3.5 Yrs.	Months Days	Hours - Min	Month, Day	1 21	Cou	SC SC
	pu &		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	postion					
	ehow	5		10	Baltimo						10d. Inside City Limits 1 XYes 2 No
	the Maryla 28a-f ehor	Director	MD NA		Daltimo						
	with a or		10e. Street and Number			10f. Zip Code	1015	1	log. Citizen of		ntry?
	n 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show salkal Examiner must be notified at	Funerai	2504 Oakley Av	12. Was Decedent Ever	2110:40		L215	2		S.A.	
	Item Item	ů,	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	r In U.S. 13.	If Yes, specify Cub	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		ce - Americ ack, White,	
38	urs aft	by	Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2X No	Specify:		Speci	ify: E	Black
Maryland 21215-0036	72 hours after 'naturel', or ite		15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation		16b. Kind of 8		
215		pie	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo	orking			acony
27	d withir glene. or then	Completed	12th grade	4yrs	Red	gistered	Nurse		Childr	cen H	Mospital
B	other of	ø	17. Father's Name (First, Middle, Last)				me (First, Middle, i			
<u>a</u>	Aenta Aenta TKed	To B	Thomas Stukes				Hatti	e Mae Si	tukes		
ary	es 1 and 2 should be filed withing the Health end Mental Hygiene. If Item 27 Is marked other then it other traumatic event, the Merical Health end in the Health end in the Merical Health end in the Me		19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Street		ural Route Number		n, State, Zip	Code)
	alth e		Gloria Taylor-I	aughter				Baltimo			.215
ē,	s 1 a f Hei item othe		20a. Method of Disposition	2	Ob. Place of Dispo				20c. Location		own, State
Ë	Page ent c nt: If ry or		1 🏋 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	King Mer		1	/1/06	Randal	llsto	wn, Md
Baltimore,	permit. Pages 'Depertment of the Important: If its eny injury or ot once.		21. Signature of Funeral Service Lice			Name and Addre					,
ä	Depermine Depermine on in in poore		Ellime of	. Ikampe	Ma A	arch F/F	i West	, Baltin	more.	БМ	21215
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the						114	Approximate
2	Dhysisian		Immediate Cause (Final	0							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		unonia						36hrs.
	Examiner			Due to (or as a co	los in						
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co							
V	uted d ansit	틀	cause. Enter Underlying Cause (Disease or injury that initiated events								
,	executed in and ial-transit	Examiner	resulting in death) Last	C. Due to (or as a co	nsequence of):						
8760,	cate be executed physicien and the burial-transit	dicai	(d							
9	tifica ig ph as th	led									
Box	n certific anding p use as t	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		7			23d. Da	ate of delive	erv
-	death e atten	Cia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		JEctopic pregnancy Other (specify)				onth	Day Year
P.0	t the by th	Physician/Med	9 □Unknown	9□ Unknown							
	The law requires that the death certific He has been signed by the attending p page 2 should be detached for use as		Part II. Other significant conditions	ontributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use con	tribute to th	ne cause of death?
ğ	equire an sig	ed						1 □ Ye	s 2 No	3 🗆 Prob	ably 4 □Unknown
8	aw re	piet						24a. Was a		Were auto	psy findings available
æ	The te ha	Completed by						autops	ned?	prior to cor death?	npletion of cause of
Division of Vital Records,	en: rtifice tor, p	0	25. Was case referred to medical				26 Place of Dea	ath (Check only on		1 🗆 Yes	2 No
>	ysici is cei direc	ToB	examiner? 1 ☐ Yes 2 █ Mo	Hospital:	2 ☐ ER/Outpatien	t 3 DOA Oth	00	lome 5 ☐ Reside		ner (Specifi	4)
0	19 Ph		27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time of			28d. Describe ho			7
<u>ō</u>	ath. r: A(atlo	1 ♥ Actural 5 ☐ Pending 2 ☐ Accident investigatio		ar) Injury		k? Yes 2 □ No				
Vis	er de ecto by th	2	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of injury -	At home, farm, str	eet, factory, office		28f. Location (St	reet and Numb	ber or Rura	l Route Number,
	s effe	Certification:	- I Tomoldo	building, etc. (S	р а спу)			City or Town	, State)		
	To the Hospital or Attending Physicien: The law within 24 bours effer death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Ph	ysician: To the best of my	y knowledge, death	occurred at the tin	ne, date and place	, and due to the ca	use(s) and m	anner as st	ated.
	he H in 24 he Fi	Medicai	(Check only 2 Medical Examone)	niner: On the basis of exa and manner stated.	mination and/or inv	restigation, in my o	pinion, death occu	irred at the time, da	ite and place,	and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License	e number	25	d. Date signe	ed (Month, L	Day, Year)
			Chronaui-	<u> </u>		RES.	han		بليسين	0.4	2151
-	11	-	30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)	UDU	- N	UVITUALY	×	, 2006
_	1		Suvasania k.	Charanto'	HD C	sinai 1to	Apital	AD	alh'mo	w l	,
	Sta	te	31. Date filed (Month, Day, Year)	-32 Aegistrar's S	Signature	CARD D	111111	0 13			`
	Registr	ar	NOV 3 0 2	106 Been	JU 1478	The state of the s					

Atalee c. Forman.

Patriot Known os

38037

			1 - State Registrar		Cei	tificate of	Death		Reg. No.		
	Physici	an	1. Decedent's Name (First, Middle, Last)	Archie	F :	itzgerald	Jr.	2. Date of De	ath Day	Year	3. Time of Death
	/Medic		- MCHIL	11/201	196	\		NOU	19 LC	06	8-304 M
	Examin	er	4a. Facility Name (If not institution, give str				r Location of Death	4		y of Death	a
			Ellicott City He 5. Social Security Number 6. Sex	alth & Rebai 7. Age (In yrs. las		If Under 1 Year	icott Ci	8. Date of Bird	th	owar	Olace (State or Foreign
	Funeral Director		217-24-2745 ¹⁻¹ X1	¹ ² □ ^F 75	Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da 01 19	9 31	Cour	VA
	and w		Usuel Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Lo	cation				1	10d. Inside City Limits
	Ba-f sho	Director	MD NA	Bal	timo	re					1∏Yes 2 □ No
	h with th	al Dire	10e. Street and Number 5362 Cordelia A	ve		10f. Zip Code	1215		10g. Citizen of U •	S • A •	ıtry?
020	be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "natural", or Itams 23a or 28a-f show event, Ita Madical Evanti at mart te notified at	by Funeral	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:	i	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ce - Americ ack, White, ify: Bla	etc.
2	"natur	leted	15. Decedent's Educa (Specify only highest grade	tion com <i>pleted)</i>	(Give	lent's Usual Occup kind of work done OO NOT use retired	during most of worki	ing	16b. Kind of E		_{dustry} atterson
21215-0036	filed within Hygiene. sthar than "	Completed	12th grade	College (1-4or 5+) Lyrs			of Secur	rity	Home	-y -	
Maryland	ould be file Mental Hy warked oth	Be	17. Father's Name (First, Middle, Last)	rald Sr			18. Mother's Name Octavia		Maiden Suma	me)	
	# D F F	2	Archie C. Fitzge 19a. Informant's Name/Relationship (Type Clary		19b. Mailir		and Number or Rura		er, City or Town	, State, Zip	Code)
	alith a		Willie A. Clary	rCousin	5362	Cordel	ia Ave,	Balti	more,	Md	21215
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animore,	Page ment o ant: If ury or		1 Surial 2 □ Cremation 3 □ Rei 4 □ Donation 5 □ Other (Specify)		riso	n Fores	t Vet.]	1/30/	06 Owi	ngs	Mills, M
	permit. Pages Department of h Important: If Its any Injury or of once.		21. Signature of Funeral Service Licensee	ark	M 4	Name and Address arch F/ 300 Wab	h°₩est ash Ave,	Balt	imore,	Md	21215
	Priysician		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	Do not ent	,	ng, such as cardiac c	or respiratory ar	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner			Production (or as a consequent	ATL	URE					
	led sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	ice oi):	2 (ED 4	D) (7	FASE			
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68760,	certificate be executed ding physician and se as the burial-transit	/Medical	d.	ENCEYTIS	4 10	YATH	J				
		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	t. If yes, outcome of pregnance 1□Live birth 2□Fetal de 4□Pregnant at time of deat 9□Unknown	eath 3	Ectopic pregnancy Other (specify)	,			ate of delive onth	ery Day Year
rds, P.	The law requires that the death ste has been signed by the atter page 2 should be detached for u	by	Part II. Other significant conditions control	ibuting to death but not resulting	ng in the u	nderlying cause giv	en in Part I.			atribute to th	ne cause of death?
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VII.	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	spital:		Oth	26. Place of Death				
o	Jing After fune	tlon; To	1 Yes 2 No 27. Manny of Death 1 Vatural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ EH	VOutpatien Bb. Time of Injury	28c. Injun	4 ursing Ho		dence 6 Ott		1
=	i Dife	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office	1	28f. Location (5 City or Tox		ber or Rura	I Route Number,
	To the Hospital within 24 hours a To the Funaral completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	cian: To the best of my knowle r: On the basis of examination and manner stated.	edge, death and/or inv	occurred at the tin restigation, in my o	ne, date and place, a pinion, death occurr	and due to the o ed at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
	withi To t	M	29b. Signature and title of certified	/ ND		29c. Licens D 5	number 87		29d. Date signe	124	Day, Year)
	5		30. Name and address of person who com	pleted cause of death (Item 23	3a) (Type,	Print) 300	Hemory	GUE	Suite	30	7

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) NOV 3 0 2006

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 29 2006 Month Physician Farrow 4a. Facility Name (If not institution, give street and number) 1:37 PM November /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Northwest Hospital Center BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Months 214 20 607 Director MAY 6 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" -- "any injury or other traumatic every". 10c. City, Town or Location 10a. State 10d. Inside City Limits NKSBURG Director 1 ☐ Yes 2 No CARROLL MO 10e. Street and Number 10g. Citizen of What Country? 4600 21048 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No Specify: by Specify: 3 Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Boltimore Co Elementary/Secondary (0-12) College (1-4or 5+) EMPLOYER ceteria BO OF EOUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George MARGARET 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road Stkesville, mo 4738 ISAKBARA SYKESUILLE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, mo 12/2/2006 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ZUMBRULH & MOV. Co ELDENSBURG-MO21784 6028 SYKESUILLE 23a. Rant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute with chronic respiratory disease or condition resulting in death) /Medical **Examiner** nd Stage (hro) Due to (or as winsequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner been signed by the attending physician and should be detached for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown pneumonia. VoeIL 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No disease 24a. Was an After this certificate has autopsy performe Metabolic bone disease, Paroxysmal 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 👿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) November 29 2006 028462

State Registrar 31. Date filed (Month, Day, Year)

NOV 3 0 2006

DHMH 17 Rev 1/2001

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J Boston Northwest Hospital Center Randallstown Maryland 21133

State of Maryland / Department of Health and Mental Hygiene 2006 38039 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 20, 2006 Physician FRIMAN 10:35 A M ROBERT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE 4210 FALLSTAFF ROAD BALTIMORE If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 08/02/1937 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 M 2□F Months Hours Yrs MD 69 217-34-4845 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State ir than "natural", or Itams 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director BALTIMORE BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21208 4210 FALLSTAFF ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married WHITE 21215-0036 1 ☐ Yes 2 No Specify Specify δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 te marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) CITY OF BALTIMORE **CLERK** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be FRIMAN GELTMAN SARAH SAMUEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
130 SLADE AVENUE305 BALTIMORE, MD 21208 19a. Informant's Name/Relationship (Type, Print) is 1 and 2 si of Health an item 27 te r MARTIN BONDROFF / BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) SFARD Baltimore, 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State (ADATH ISRAEL) ANSHE 11/29/2006 DUNDALK, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Total 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Physician /Medical Due to (or as a consequence of) Examiner Esquentially liet our different any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical attending physic for use as the b IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a o. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, sign be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy 1 ☐ Yes 2 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural 2 ☐ Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funarel Director: , completely filled in by the f 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tole of certifier November 272006 18667 30. Name and address of person who completed cau e of death (Item, 23a) (Type, Print) CT. Luthenville MD 21093 6 Trumble Hill MU Philip Militello 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2006 NOV 3 0

Frimani

11/20/06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 38040 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Arthur Thomas Fitzgibbons 4:00 PM 22 2006 November 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bultimore atonsville Summit Reheels. + Hould Park If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) Apr 25, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 X M 2 □ F Yrs 1922 Maryland 213-14-5308 84 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No N/ABaltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21230 508 East Randall St., Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify 3 XWidowed 4 Divorced White WW 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore Inspector 0 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Thomas R. Fitzgibbons Mary Emma Cumberland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 805 Francis Ave., Balto., Md. Delores C. Lembach (Daughter-in-law) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Bayview Crematory, Inc. 11/29/06 Baltimore, Maryland `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furral Semice Licensee Kevin E Ecker ^{22, Name and Address of Facility} McCuIly-Polyniak Funeral Home, P.A. 130 E. Fort Ave., Balto., Md. 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YPUS melanoma Metostic disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Completed by Funeral

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10a. State

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eraning India to the result.

Baltimore, Maryland 21215-0036

burial-transi the attending physician use as the certificate has been signed by this Hospital or Attending 24 hours after death.

F. trgibbon

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

1 ☐ Yes 2 ₽ No

27. Manner of Death

1 XNatural

2 Accident

3 Suicide

29a. Certifier

4 | Homicide

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 4☐Pregnant at time of death 9 Unknown

3 □Ectopic pregnancy 5 Other (specify)

pulmonory

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? Yes 22 No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

Year

253No 1 Yes 26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of

1 ☐ Yes 2 ☐ No M 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Ave

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Bultimore

(Check only one) 29b. Signature and title of certifier

NOV 3 0 2006

5 Pending investigation

6 Could not be

determined

29c. License numbe 6275 29d. Date signed (Month, Day, Year)

11/28/06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 3455 Willens askaran

32 Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Diractor:

24 hours a

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		FAmend Items 24a	,27,20,27,2	Ce	rtificate of	Death	MARKE	Re	eg. No.	00	3804
hysici	an	Decedent's Name (First, Middle, Last,)		-		2	2. Date of Deat Month	h Day	Year	3. Time of Death
/Medic		Charlotte Green						Novemb	T		12:23 AM
Examir	er	4a. Facility Name (If not institution, give Washington Adven		- a 1	4b. City, Town, o		of Death		4c. County Monte		V
		5. Social Security Number 6. Sec		yrs. last birthday)	If Under 1 Year			B. Date of Birth	1	9. Birtho	place (State or Foreig
ineral rector]м 2∏Г	93 Yrs.	Months Days	Hours	Min.	(Month, Day, uly 26		Cour	inois
		Usual Residence of Decedent									
ehov H H	_	10a. State 10b. County MD Montgome		c. City, Town or Lo	Spring					1	1 ☐ Yes 2√ N
28a-f	Director	10e. Street and Number	Ly	PITAGE	10f. Zip Code			1	0g. Citizen of V	Mh a t Caur	
Pe Or	2	3116 Gracefield R	2024 #309			20904			-		nu y :
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io in	ted	15. Decedent's Edu (Specify only highest grad			dent's Usual Occup		t of working		16b. Kind of Bu	usiness/In	dustry
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aumatic	٤	19a. Informant's Name/Relationship (T)		10b Maili	ng Address (Street		Balkir		City or Town	Ctata Zia	Code
item 27 is marke other traumatic		Susan Green/daug			Duke Dr:					0902	Code
other		20a. Method of Disposition	2	20b. Place of Dispo		1	Dat	_	20c. Location -		own, State
eny injury or of		1 Buriat 2 Cremation 3 F 4 Donation 5 Other (Specify)									
eny i		21. Signature de puneral Service licens	/11/LK	E 14	2. Name and Addre Late Anat Linore,	MD 2	21201			ore S	treet
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tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у			23d. Dat Mor	e of delive	ery Day Year
be deta	by Ph	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the u	nderlying cause giv	ven in Part I.		23e. Did tob	acco use conti	ribute to th	ne cause of death?
should	ted							1 Ye	s 2 No	3 Prob	ably 4 Dunknow
page 2 sh	Completed					-	_	24a. Was ar autops perform 1 Yes 2	n 24b. \ y nad? c	Vere auto prior to con death? Yes	psy findings available mpletion of cause of 2 No
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the f	icat	2 Accident investigation 3 Suicide 6 Could not be	290 Place of Injury	At home form of		Yes 2 N		f Location /St	root and Numb	or or Pum	d Route Number,
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completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exemi	sicien: To the best of m ner: On the basis of ex and manner stated	amination and/or in	h occurred at the til vestigation, in my o	me, date and opinion, deat	d place, and th occurred	d due to the call at the time, da	use(s) and ma	nner as st and due to	tated. o the cause(s)
complet	Me	29b. Signature and title of certifier	N. IDAH	nanii.c	29c. Licens			25	d. Date signed	(Month,	Day, Year)
~		M. Done	(KAI	NANI.S	(V) DO	063	25%		11/30/	06	
		30. Name and address of person who co					.50				
		Ramani S. Nokku, M			ventist l	iospit	al. T	akona 1	Park. II	D 209	912
	1 1			0		10 20 10 0					

ORIGINAL

State of Maryland / Department of Health and Mental Hygien (For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** EDWARD A. GRIFFITH NOVEMBER 27, 2006 10:29 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 10/11/ 9. Birthplace (State or Foreign Country) MARYLAND 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1922 1 M 2 □ F Director 215-14-9660 84 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic svent, the Medical Examinar must be notified at 1 Yes 2 No Director BALTIMORE COCKEYSVILLE MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 13801 YORK RD 21030 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 SYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) 4YRS Elementary/Secondary (0-12) BROKER & APPRAISER COMMERCIAL REAL EST. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H is marked of EDWARD R. GRIFFITH JEAN LEONARD ဥ Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 19a. Informant's Name/Relationship (Type, Print) Peges 1 end 2 13801 YORK RD APT. J-12 COCKEYSVILLE, MD JOYCE T. GRIFFITH(WIFE) item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges Department of Importent: if it eny injury or o ō 1 Burial 2 □ Cremation 3 □ Removal from State 12/2/2006 NEW CATHEDRAL BALTO CITY, MD. 4 □ Donation 5 □ Other (Specify) RENRY W. JENKINS & SONS CO 16924 YORK RD MONKTON, MD. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** asustole disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oxemia Sequentially list conditions, any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cua to for as a o Physician/Medical Examiner inding physicien and use as the burial-transit The law requires that the death certificate be executed atelec Due to (or as a consequence of) Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown ed by t detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by sign 1 be 1 ☐ Yes 2 TNo 3 Probably 4 □Unknown CUSTI 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 2. No 1 Yes the Hospitel or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 No Hospital: 1 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident Injury s efter de...-ni Diractor: Atte 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours e To the Funeral E 29a. Certifier Kartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 57-N. Char 25 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Wonth Ovember Day GARRISON BERNICE Т. Baltimore acility Name (If not institution, give street and number Town, or Location of Death 4c. County of Death If Under 1 Year If Under Date of Birth (Month, Day, Year) 12-29-1929 last birthday Birthplace (State or Foreign Country) 1□ M 2 F Days 075-22-3768 76 NC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 TYYes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4803 TAMARIND ROAD 21209 APT. 426 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 □ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DISABILITY CONSULTANT SOCIAL SECURITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HENRY LAMB THELMA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENISE SALISBURY/DAUGHTER 2045 E. BELVEDERE AVE. BALTIMORE, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST CEM. 12-5-06 OWINGS MILLS, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. BALTIMORE, MD 21217 1701-31 LAURENS ST. 23a. Part / Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one page on each line. Approximate Interval Between Onset and Death , I cu Due to (or as a consequence of) due to for as a consequence off Due to (or as a consequence of):

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

is marked other

Important: if item 2 any injury or other

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Director

Funeral

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Completed

Be

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with the Maryland

Baltimore, Maryland 21215-0036

signed to this Director: within 24 hours are
To the Funeral Dir

To the Hospital or Attending Physician: The law requires that the death certificate be executed

hours after

Division or Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Examine if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 PNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 Tes 2 □ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and address of person who completed cause

DHMH 17 Rev 1/2001

MD

of death (Item 23a) (Type, Print)

32 Registrar's Signature

		1	State of Maryland / [Department of Health Certificate of Deat	i h	giene 005	38044
	,		Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of De	ath Day Year	3. Time of Death
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	/Medic Examin	aı 📑	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	ion of Death	4c. County of Deatl	1
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	and and	ŀ	10a. State 10b. County 10c. City, Tow	n or Location			10d. Inside City Limits
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ylai	2 should be f and Mental I Is markad of raumatic ave	2	Charles W. Tillman	D. Mailing Address (Street and Nu	ra Simons	per City or Town State	Zin Code)
Maryland 21215-0036	and and rism			.56 Madonna Rd.,			
e,	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene if Health and Mental Hyglene itam 27 Is markad other than "natural", or Itams 23a or 28e-f show itam 27 Is markad other than "natural" or Itams Italiad all other traumatic avent, Ital Medical Examinar Is used to a lifted all		20b. Place (of Disposition (Name of	Date	20c. Location - City or	
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Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other t		21. Signature era eroce Lic nsee	22 Name and Address of E	acility		
Ba	Dep Imp any		Michael J. Flagle	Lemmon Funera 10 W. Padonia	a Rd., Timoni	um, MD 2109	3, 1110.
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Division of Vital Records,	or Ar after Direction by	Certification:	4 Homicide determined building, etc. (Specify)	,	City or I	own, State)	
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1	0		30. Name and address of person who completed cause of death (Item 23:	a) (Type, Print) DR MAN	NAING	00, MD.	
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DHMH 17 Rev 1/2001

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Funeral Director		5. Social Security Number 218-22-3997 Usual Residence of Decedent	D11 005	Yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 09/28)	Year)	Birthplace (State or Foreign Country) CAROLINA
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and 2 should and 2 should lealth and Men m 27 is marke her traumatic		19a. Informant's Name/Relationship (EDWARD HENDER		19b. Mailir ANDSON	g Address (Street 2206 W	and Number or Run	al Route Number, TE ST.,	City or Town, Sta	nate, Zip Code) 21223 NORE, MD
J 0 0 - 5		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification of the control of the contr	Removal from State		sition (Name of natory or other pla ON NATL	ce) ;		0c. Location - Cit	y or Town, State
Dallullion permit. Pages Department of Important: if is any injury or o		21. Signature of Funeral Service Licer	nsee /		Name and Addre	п			HOME 21207 TIMORE, MD
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To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	4 ☐ Homicide determined	building, etc. (Sp.	ecify)			City or Town,	State)	or Rural Route Number,
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, 9		30. Name and endress of person who	(= - 1 t-	211	0011	MMan	Park	Dave	21211
Sta	-	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	99	- Janan	10111	2.00 <	5 - 0 - 1
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State of Maryland / Department of Health and Mental Hygiene 2006 38046 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician NOV. MELVIN HOWARD 28 2006 2:08A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** N/A GOOD SAMARITAN HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** Months 1□M 2□F 73 219-28-4849 06/01/1933 MARYLAND Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State Item 27 is marked other than "natural", or Items 23s or 28s-f show other trsumetic event, it is Medical Examinar must be notified at BALTIMORE CITY N/A 1 □X es 2 □ No MD Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21212 USA 809 BENNINGHAUS ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 14. Race - American Indian, Black White etc. US filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: BLACK If Yes, Give Year or Dates: ARMY þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) HYDRO DERM CORP. FORKLIFT OPERATOR 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked oth any injury or other trsumatic event poice. Be TAYLOR HERMAN HOWARD SR. WILLIE MAE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 809 BENNINGHAUS ROAD, BALTIMORE, MD 21212 JOYCE HOWARD / 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other t Date 20a. Method of Disposition 1 🌠 Burial 2 □ Cremation 3 □ Removal from State 12/04/06 OWINGS MILLS, MD MD VETERANS CEM 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST Facility HOWELL FUNERAL HOME 21207 21. Signature of Euneral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease if condition CARDIAC ARRYTHMIA Priysician 4hB resulting in death) /Medical 3×Re Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner MULTIPLE use as the burial-transit Division of Vital Records, P.O. Box 68760, ed by the attending physicien detached for use as the buria 20 488 IDDA certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ A-THEROSCIEROTIC ASCULAR 1 🗌 Yes 2 3 № 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 Tyes I or Attending Physicien: after death. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 XER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. 28d. Describe how injury occurred After 1 Natural 5 Pending after death. 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funerel D Hospitel 1 Contifying Physiciam To the best of any knowledge death accured at the time data and users, and diset. The nause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 22,652 2006 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pr. S SRINIVAS 5601 LOCHRAVEN BLVD BALTIMORE MD 21239 Hr. S SRINIVAS Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 NOV 3 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38047 State of Maryland / Department of Health and Mental Hygien () () Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Nov 27, Year Edward Hutchinson 2006 1:00P 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death George Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 213 40 9263 63 Yrs. 1943 Nashii (Usual Residence of Decedent 10b. County 10c. City, Town or Location IOd. Inside City Limits 1 ☐ Yes 2√ No Prince George Capital Heights 10e. Street and Number 9415 Chestnut Park Street 10f, Zip Code 10g. Citizen of What Country? 20745 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 XX If Yes, Give Year or Dates: XX Never Married 2 Married 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Kojak Sheetmetal Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hutchinson Alice Windsor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9415 Chestnut Park Street, Capital , MD 20745 Marie L. Connell 20a. Method of Disposition

LAMBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec 1, 2006 4 ☐ Donation 5 ☐ Other (Specify) Epiphany Church Cemetery Forestville, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

tited within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any Injury or other traumatic event, the Modral Examiner must be notified at once.

Richard

Prince

10a. State

11 Marital Status

12

Archie

MD

by Funeral Director

Be Completed

5. Social Security Number

within 24 hours after death.

To the Funeral Director: A
completely tilled in by the to

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

Į.	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Luny Concer Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	b pulen	Zease
חוכשו באשווווו	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of): d.		
ysicializme	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
בת הא רו	Part II. Other significant conditions c	ontributing to death but not resulting in the underlying cause given in Part I.	_	use contribute to the cause of death? 2 No 3 Probably 4 Unknow
ooiiibier			24a. Was an autopsy performed?	
Ď.	25. Was case referred to medical	26. Place of Death (Check only one)	
2	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 🖺 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Other: 4 🗆 Nursing Home	5 Residence	6 □Other (Specify)
allon.	27. Manner of Death 1 XNatural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No	d. Describe how inj	ury occurred
=	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office	f. Location (Street a	and Number or Rural Route Number,

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier Shel ella

29c. License number 18662000 29d. Date signed (Month, Day, Year) 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL DRIVE 3061

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MUKEMIL 31. Date filed (Month, Day, Year)

ABDELL 32. egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 38048 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death R 27 NOVEMBER JOHN A. HOY JR. 2006 0446 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death UPPER CHESAPEAKE MED. CENTER BELAIR HARFORD 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) 07/13/1933 MARYLAND If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1**X** M 2□ F Months Hours Min. 73 216-28-8058 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No HARFORD WHITE HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21161 4841 AMOS RD USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 4YRS HORSEMAN HORSEMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN A. HOY SR. VIRGINIA HICKEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4841 ANNE H. PATSCHE (DAUGHTER) AMOS RD WHITE HALL, MD. 21161. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY 11/29/2006 BALTO CITY, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD MONKTON, MD. 21111. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Rave pe to (or as a consequence of) Du to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Caranana 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an

Physician /Medical Examiner

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filled in by the

completely

within 24 hours a To the Funeral I

Certification: To Be Completed by

Medical

Pages 1 and 2 should be nent of Health and Mental

and l

Department of Health a important: If item 27 is any Injury or other trauonce.

Physician

/Medical

Examiner

Director

Funeral

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Completed

MD

Funeral

Director

ed other than "natural", or Items 23a or 28a-f show event, the Metical Examiner must be notified at

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗓 No

4 Homicide

Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy

25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 □ No 2 X ER/Outpatient 3 DOA 5 Residence 6 Other (Specify)

Manner of Death 1 Natural 2 ☐ Accident 5 Pending investigation 6 ☐ Could not be 3 ☐ Suicide

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 28b. Time of 1 □ Yes 2 □ No

28d. Describe how injury occurred 28f. Location treet and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

NOV 3 0 2006

determined

who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

State Registrar

			1- State of Maryland / De State of Maryland / De	partment of Health and N e <i>rtificate of Death</i>	fental Hyg	iene 2006	38049
F	Physici		1. Decedent's Name (First, Middle, Last) MARYAM	HAMAD	2. Date of Deat Month November	Day Year	3. Time of Death 2:16 A M
1	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	~ ~ /	4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth	9. Birth	place (State or Foreign
	Director		205-68-7965 1 M 2⊠F 2 Yrs. Usual Residence of Decedent	Months Days Hours Min.	(Monjh, Day, 3-27-20)	04 Virg	
	aryland show	<u>_</u>	10a. State 10b. County 10c. City, Town or	Location		1	10d. Inside City Limits
	the Ma	Director	Virginia Fairfax Annandale 10e. Street and Number	10f. Zip Code	10	Og. Citizen of What Cour	1 ☐ Yes 21 No
	23a or		4616 Wakefield Chapel Rd.	22003		USA	,
36	hours after death with the Maryland tural', or Items 23a or 28e-f show al Examitter must be notified at	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 12. Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes, 3 We If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify: 	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
21215-0036	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other than "natural", or items 23a or 28e-f show event, the Macinal Extendible rules be notified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work . DO NOT use retired)	ing	16b. Kind of Business/In	dustry
	filed w Hygier other ti		17. Father's Name (First, Middle, Last)	N/A 18. Mother's Nam	e (First, Middle, N	N/A Maiden Sumame)	
Maryland	should be file and Mental Hy marked oth umatic event	To Be	Ronnie G. Hamad	Iman Ell	kassrawi		
Mar	Cl = 0	ı		iling Address (Street and Number or Rur Meadow Hall Dr. He			Code)
Baltimore,	Pages 1 and nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 20b. Place of Dis	position (Name of rematory or other place)	Date 2	20c. Location - City or To	
Balti	permit. Pages Department of i Important: If it any injury or o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Nat 7482 Lee HWY. Fall:	ional Fu	uneral Home	
F			23a. Part1. Enter the disease, or complications that caused he death. Do not e shock, or heart failure. List only one cause on each line.				Approximate Interval Between
N.	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a	(A			S Mene 445
8		niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
8/60, 7	ficate be executed physicien and s the burial-transit	ai Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
9	rtificate ng phys as the	Aedicai	d.				
C. Box	w requires that the death certif been signed by the ettending should be detached for use as	Physician/Me		B Ectopic pregnancy Country Country		23d. Date of delive Month	ery Day Year
ds, P.	requires that the een signed by th hould be detache	ρ	Part II. Other significant conditions contributing to death but not resulting in the PROBRESSIVE ACIDOSIS AND RESPIRATORY		23e. Did toba	acco use contribute to th	
Hecords,	e faw requ hes been je 2 shoul	Completed			24a. Was an autopsy perform	24b. Were auto	psy findings available mpletion of cause of
_	ien: The rtificete he tor, page	0	25. Was case referred to medical	26. Place of Deat	1 ☐ Yes 2	No 1 □ Yes	2 No
o 	Physic this ce al direc	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time	ent 3 DOA Other: 4 Nursing Ho	me 5 Resider	nce 6 Other (Specify	γ)
0	nding ath. r: After e funer	ation	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time 28c. Time		28d. Describe how	w injury occurred	
DIVISION	To the Hospitel or Attending Physicien: The law within 24 bours after death. To the Funers! Director After this certificete hes completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (Str City or Town,	eet and Number or Rura , State)	I Route Number,
	he Hospil n 24 hour he Funeri bletely filli	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dei 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the car ed at the time, da	use(s) and manner as st te and place, and due to	ated. the cause(s)
	To the To the comp	Σ	29b. Signature and title of certifier	29c. License number		d. Date signed (Month,	Dey, Year)
7	\		30. Name and address of person who completed cause of death (Item 23a) (Type	Res-000) N	ovember 1	1,2004
E	Sta	te	31. Date filed (Month, Day, Year) 32. Refistrar's Signature NOV 3 0 2006	Wolfest P	altimo	re Mary	lana 2128 H
	Registr	ar	NOV 3 0 2006	Course			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10d, 19b per int 8802 12-5-06 vt. State of Maryland / Department of Health and Mental Hygiene

38050 Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Donald Joseph Hawkins November 2006 1:30a /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Westminster Carroll Carroll Hospital Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 17∑M 2□F 84 Yrs. 236-20-5142 WV Director Feb 9 1922 Usual Residence of Decedent e filed within 72 hours after deeth with the Maryland II Hygiene.
other then "naturel", or items 23s or 28s-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: if item 27 is marked other then "naturel", or items 23a or 28a-f show injury or other traumatic event, it a Medical Examinar must be notified at 1 Yes 2 No Sykesville Md Carroll Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 USA 521 Manor Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 10// Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 11 Yes 2 No 1944— If Yes, Give Year or Dates: 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) electrical wireman Westinghouse Corp. permit. Peges 1 and 2 should be tite Department of Heelth and Mental Hy Important: if item 27 is marked othe eny injury or other traumatic event, soca. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Calvin Hawkins Genoa Kathryn Hawley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21074 Robert Reinhardt Jr. (POA for 5110 Mount Carmel Rd., or, MD 21102 spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-02-06 Lake View Memorial Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Dage of aight Serbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ete hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete hes autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2€No Inpatient 2☐ ER/Outpatient 3☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation s effer dec. Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours e To the Funeral C tertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D43725 11/29/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weitminister 19 140140 Road MAHMUUD IARIQ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Jam bovember /Medical Facility Name (If not institution, give 4c. County of Death **Examiner** 4b. City. Town, or Location of Death bord de Himore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 95-17-1919 5. Social Security Number (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2□F Days 217-18-5560 8 Hours Min Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1 Yes 2 □ No Funeral Director MD Hi more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 6957 Jessie vephew Didd: Na (Name of or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in Justi) Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 2 No 24a. Was an page 2 s autonsy perform 2 **AU**No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 1 ☐ Yes 2**1**0 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Mar) 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

Registrar

State

31. Date filed (Month, Day, Year)

NOV 3 0 2006

strar's Signature

32. Re

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day HOWARD L. JOHNSON NOV. 26 2006 10:45A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MILFORD MANOR NURSING CENTER PIKESVILLE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **1**X M 2□F Months Days Hours Min. 226-14-9207 87 Director 06/23/1919 VIRĞINIA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director MD N/A 1 ⊈Yes 2 ☐ No BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3914 FALLSTAFF Funeral ROAD 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, US Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1942-45 <u>Ş</u> 1 ☐ Yes 2 No Specify. Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) BETHLEHEM STEEL Elementary/Secondary (0-12) College (1-4or 5+) STEEL WORKER 8TH CORPORATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALFRED JOHNSON ည HELEN HAMLIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSLIE B. JOHNSON / WIFE 3914 FALLSTAFF ROAD, BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) MD VETERANS CEM. 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 112/05/06 OWINGS MILLS, MD GARRISON FOREST HOWELL FUNERAL HOME 21207 Funeral Service Lice 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD the disease, or complications that caused ear failure. List only one cause on each in e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immedia Cause (Final disea or condition resulting in death) **Physician** mound /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an cate 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home ို 1 ☐ Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 🗌 Yes after death 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dire completely filled in b Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 Medical Exa 29b. Signature and title of certifi

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Registrar

30. Name and address

31. Date filed (Month, Day, Year) NOV 3 0 2006

		,	For State Registrar	State of M	larylar		artment of He rtificate of D			2006	38053
	Physici		1. Decedent's Name (First, Middle, L		NE	73			2. Date of Death Month	Day Year	3. Time of Death
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ľ	Funeral Director		5. Social Security Number 244–48–5124 6.	Sex 7. A 1 □ M 2√2 F	ge (In yrs. 7.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 2-15-15	ear) Co	thplace (State or Foreign ountry) N.C.
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	the Ma	Director	Md. 10e. Street and Number	IA		Balt	10f. Zip Code		100	. Citizen of What Co	1 X Yes 2 □ No
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920	72 hours after death with the Maryland neturel; or Iteme 23s or 28s-f ehow licel Examinatroual be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 ff Yes, Give Year or Dates	?] No		Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2☐ No	panic Origin? (Spec , Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
15-0	2 2 3	leted	15. Decedent's I (Specify only highest g			(Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of workin	16	b. Kind of Business	/Industry
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Maryland	be fi	To Be	17. Father's Name (First, Middle, Las David	t)		Hines	1	8. Mother's Name Maggie	(First, Middle, Ma	Campbe	11
Mary	and and ls m	-	19a. Informant's Name/Relationship	(Турв, Print) Son		19b. Mailir	ng Address (Street and	las Ct.,	Route Number, (Baltimor	City or Town, State, Ce, Md. 2	Zip Code) 1231
	0 0		Benjamin Jones 20a. Method of Disposition 1 Burial 2 Cremation 3			Place of Dispo	esition (Name of matory or other place)	Da		c. Location - City or	Town, State
Baltimore,	트 문문을 .		4 Donation 5 Other (Spec	ity)		rinity	Cem. Name and Address	of Facility N	0-06 March F.H	Dundalk, I. East	
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1	Physician		23a. Part1. Enter the disease, or cor shock, or heart failure. List ont Immediate Cause (Final disease or condition	y one cause on each		n. Do not ent	er the mode or dying,	such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a conseq	uence of):					y ves
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O.	the death certii y the attending iched for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. ff yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	fdeath 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	iivery Day Year
rds, P	The law requires that te has been signed b page 2 should be deta	þ	Part II. Other significant conditions	contributing to death		ulting in the u	nderlying cause given	in Part I.		cco use contribute to	the cause of death?
Division of Vital Records,	has bee ge 2 sho	Completed	Renal Tr	Effic	vier	rey			24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
ital		Be Co	25. Was case referred to medical examiner?					26. Place of Death	1 Yes 2 □		2 No
of <	Phys rthis raldii	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Anpat	ury	ER/Outpatien		4 Ivursing nom	e 5 Residence	ce 6 Other (Spe	cify)
sion	Attending r death. ector: After by the fune	cation	Natural 5 ☐ Pending 2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not	he -		Injury	M 1 Ye	s 2 No			
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	To the Hospital or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying P	thysician: To the best miner: On the basis and manner s	of examina	wledge, death	n occurred at the time vestigation, in my opin	, date and place, and occurre	nd due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To th To th Comp	W	29b. Signature and title of certifier	Coeta	~	D	29c, License r			Date signed (Mont	
•	5		30 Name and address of payson who	completed cause of	/	n 23a) (Type,	Print) PA	TUL P	LACE	BAUTIN	23,2006 WE MD
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State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate Certificate		Reg No 2006	3805		
Physici Medical Exami		1. Decedent's Name (First, Middle,Last) Immanuel	Johnson	2 Date of Death Month Day Year November 26, 2006			
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
Funeral		Sinai Hospital 5 Social Security Number 6 Sex 7. Age (In yrs last birthday)	Baltimore If Under 1 Year If Under 24Hrs.	8. Date of Birth (MM/DD/YYYY) 9. Birthp	lace (State or		
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any	ŀ	Usual Residence of Decedent 10a State	ation	10	Od. Inside City Limits		
Maryland 28a-f show any 1 at once,	5	VA Richmon	nd		X Yes 2 No		
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 3445 Walmsley Blvd Apt B	10f. Zip Code 23234	10g Citizen of What Country U • S • A •	7?		
r death wi or Items	Funeral	1 X Never Married 2 Married Armed Forces? If Yes 2 X No	Vas Decedent of Hispanic Origin? (Spei Yes, specify Cuban, Mexican, Puerto R Yes 2 X No specify:	Rican, etc.) White, etc	n Indian, Black,		
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2121! uld be fill Mental H marked c event, t	Be	Charles Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mail		Harvin	- O-d-)		
AD 2 2 shou 1 and 3 27 is r matic	٦	Crystal Johnson-Mother 344	5 Walmsley Blvd	ral Route Number, City or Town, State. Z Apt B, Richmone	23234		
ore, N es I and of Health If item		1 Burial 2 X Cremation 3 Removal from State crematory or	other place)	Date 20c. Location - City or To			
Baltimore permit Pages 1 Department of F Important: If i				2/4/06 Baltimore	, Mđ		
Ba perm Depa Impo		$\mathcal{N}^{\prime\prime}$	Name and Address of Facility arch F/H West 300 Wabash Ave,	Baltimore, Md	21215		
Physician /Medical		73a. Part I. Enter the disease, or combilications that caused the death. Do not enter failure. List only one cause on each line.		respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death		
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	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
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68760, certificate be ading physicise as the buri		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 1	Fetal death 3 Ectopic pregnance	23d. Date of delivery cy Month Day	Year		
Box 68's death certiff	Physician		Other (Specify)				
b.O. E that the d red by the detached		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e Did tobacco use contribute to the	cause of death?		
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Division of Vital Records, tal or Attending Physician: The law requirers after death al Director: After this certificate has been siled in by the funeral director, page 2 should be	on: T	27. Manner of Death 1 Natural 5 Pending Find 11/26/2006 Find 7.	1 Van a Y Na	8d Describe how injury occurred			
risior Attend er death rector:	icati	Investigation Find 11/26/2006 Find /: 28e Place of Injury - At home, farm, str	reet, factory, office building, etc. 2	ink 28f Location (Street and Number or Rural	Route Number, City		
Divis	Certification;	4 Homicide determined (Specify) House	E	Baltimore, MD 2521 Quant	ico Ave.		
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certificate buts after death To the Finneral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurrence one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated					
F % F 3	Me	29b Signature and title of certifier	29c. License number	29d Date signed (Month)			
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	November 27, 2006)		
			11 Penn Street, Baltimore, MD	D 21201			
S Regis	tate trar	31. Date filed (Month, Day, Year) NOV 3 0 2006 32 Figistrar's Signature	porte				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 17, 2008 8:40pm **Physician** Sarah Lawshe Kollar /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Wilson Healthcare Center Gaithersburg If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | Ju Month Pay, 1991 9 9. Birthplace (State or Foreign 5. Social Security Number 6 SAY 7. Age (In yrs. last birthday) **Funeral** Georgia 579-14-3315 1 ☐ M 2 XF 87 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County item 27 is marked other then "naturel", or items 23a or 28e-f show other traumatic event. The Medical Examinar must be notified at 1 X Yes 2 □ No Montgomery Gaithersburg Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20877 USA 301 Russell Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white Completed by 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) iled within al Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) Financial Services Banking 17. Father's Name (First, Middle, Last)
Fred Whitney Lawshe 18. Mother's Name (First, Middle, Maiden Surname) Be Beatrice Guild should be Mental and Mental ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 12739 W. Bethany Home Rd. Litchfield Park, AZ85340 item 27 Stephen Kollar / son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Important: If iter
eny injury or oth 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) National Memorial Pk Nov. 29,2006 Falls Church, Va 21. Signature of Funeral Service Licensee 22. Name and Address of Facility National Funeral Home 7428 Lee Highway Falls Church, Va 22042)hey 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebral Vascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year for 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>^</u> X 2□No Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 TYes Hypothyroidism Completed 24a. Was an autopsy performed?
1 Yes 2 No Dementia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 has funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 13 or Attending After 1 XNatural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C Hospitel 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number D35791 1 Wenne nuu 30. Name and address of person who completed cause of peats (Item 23a) (Type, Pript 9801 Georgia Avenue Silver Spring, MD 20902 Merlyn Vemury, M.D. 31. Date filed (Month, Day, Year) NOV 3 0 2006 32. Registrar's Signature State Registrar

			1 - For Amend #23b F State Registrar 1. Decedent's Name (First, Middle, Last,	erathy (8801a)	1/36/0 Cer	etment of l of Jn tificate of	lealth and I Death	Mental Hyg		006	3 8 0 5 6
)	Physici /Medio Examir	al	Thomas Xavier K	eefe Sr.		4b. City, Town, o	or Location of Death	Nov.	22 4c. Cou	2006 unty of Death	10:00A M
	Funeral Director		Stella Maris 5. Social Security Number 6. Security Number 219-42-6173 Usual Residence of Decedent	7. Age (In yrs.)	last birthday) Yrs.	Timo If Under 1 Year Months Days		8. Date of Birth (Month, Day, Aug. 27	Year)		ce (State or Foreigr y) York
:	nous arer deem with the maryand tural, or iteme 23a or 28a-f show al Examiner must be notified at	Director	10a. State 10b. County MD Baltimor 10e. Street and Number 2525 Pot Spring	e Tim	y, Town or Loo	10f. Zip Code	0.2	10		of What Countr	d. Inside City Limits 1 Yes 2 No X
200	rious alter deem with the malytal ural, or iteme 23a or 28a-1 show al Examiner must be notified at	d by Funerai		12. Was Decedent Ever in U. Armed Forces? 1. 1 1 2 Yes 2 □ No If Yes, Give Year or Dates:			dispanic Origin? (S an, Mexican, Puert Specity:	pecify Yes or No- o Rican, etc.)	14. [Race - Americar Black, White, et ecity: whit	c.
61213	Hygiene. Hygiene. Other than "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give A	ent's Usual Occup kind of work done OO NOT use retire	during most of wor d)	king	Feder	of Business/Indu	
al ylalı	snould be ind Mental i marked (umatic ev	To Be	17. Father's Name (First, Middle, Last) Eugene Keefe 19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street		ne (First, Middle, Men Sullivers Sullivers) Trail Route Number,	an		ode)
ָ טֿ	permit. Pages I and a Department of Health a Important: if item 27 is any injury or other tra		Mr. Gerard Keef 20a. Method of Disposition Disposition Comparison of	lemoval from State Du1	Place of Disposemetery, crem	sition (Name of latory or other pla alley Me Name and Addre	morial Ga	Date 25-06 ardens Ti	20c. Location	on - City or Tow	n, State
	hysician /Medical Examiner	er	23a. Part I. Enfer the disease, or complete shock or hear failure. List only of Immediate Cause (Final disease or condition resultinglin death) Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	n. Do not ente	or the mode of dyin		or respiratory arre	est,	li c	Approximate interval Between Driset and Death
-	learn cerminate be executed attending physicien and I for use as the burial-transit	Medicai Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent		roke				U	neeks
	9 9 8	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3 🗌	Ectopic pregnanc Other (specify) _	У		23d.	Date of delivery Month D	/ Day Year
- 620	ine law requires mat me ite has been signed by th bage 2 should be detache	þ	Part II. Other significant conditions con	ntributing to death but not res	ulting in the un	derlying cause giv	ven in Part I.		s 2.15 N	o 3 Probat	cause of death?
		e Completed	25. Was case referred to medical				26 Place of Dea	24a. Was ar autops perform 1 Yes 2	No No	4b. Were autops prior to comp death? 1 Yes 2	sy findings available pletion of cause of No
	After this uneral di	tion: To Be	examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju	ner: 4.2 Nursing H	ome 5 Reside	nce 6 🗆		
=	nospites of Attending 4 hours effer death. Funeral Director: After tely filled in by the funer	I Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specifi sician: To the best of my kno	y)	eet, factory, office		28f. Location (Str. City or Town	, State)		
:	within 24 ho To the Fund completely f	Medical		nar: On the basis of examina and manner stated.			opinion, death occu	rred at the time, da	ate and pla		he cause(s)
07	4		30. Name and address of person who con ERNESTINE WRI				NEY VAL				MD 210
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture doe	elle s					

DHMH 17 Rev 1/2001

10:00 A.M.

NOVEMBER 22, 2006

KEEFE, THOMAS

State of Maryland / Department of Health and Mental Hygien 2006 38057 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November 21, 2006 Physician Michael P. von Kaenel 7:55 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9212 Orchard Brook Drive Montgomery Potomac If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 29, 19 Birthplace (State or Foreign Country) Social Security Number **Funeral** 1MM 2□ F 63 Yrs 1943 Washington, DC Director 579-54-5321 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f ehow the Medical Examiner must be notified at 1 Yes 2K No Directo Maryland Montgomery Potomac 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code or Iteme 23a or 9212 Orchard Brook Drive 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? 1Â∑Yes 2 □ No If Yes, Give Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 24 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: á 3 Widowed 4 Divorced White "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Owner/Operator Iron Works permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if item 27 is marked other eny Injury or other treumatic event, I 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Paul von Kaenel Ellie Abrecht 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9212 Orchard Brook Drive Potomac, Maryland 20854 19a. Informant's Name/Relationship (Type, Print) Margo W. von Kaenel/Wife Potomac, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery Date 20c. Location - City or Town, State 20a. Method of Disposition November 30, 1 □ Burial 2 ☑ Cremation 3 □ Removat from State Bethesda, Maryland 4 □Donation 5 □ Other (Specify) rium, Inc. 2006 Beth

22 Name and Address of Facility Robert A. Pump
ROCKVIIIE, Inc. 300 West Montgo
Rockville, Maryland 20850-2805 Crematorium, Inc. Pumphrey Funeral Home/ 21. Signature of Funeral Service Licensee Montgomery Avenue M00803 Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Bladder Cancer 1 Year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and the for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? After this certificate has 1 Yes Be (25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 AResidence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending is within 24 hours after death. To the Funerel Director: After 1X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ffcertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and itle of certifier 29c. License number D45380 November 22, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1396 Piccard Drive, Rockville, Maryland 20850 Leon Hwang, M.D. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 3 0 2006

		1	For State Registrar	State of M	laryland /	Depa Cer	irtment <i>tificate</i>	of He	ealth ai Death	nd Me		iene2 (06	380	58
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	/Medic Examin	21	a. Facility Name (If not institution, give s	treet and number	·)				Location of	Death			ty of Deat		
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	Funeral	:	Social Security Number 6. Sex		ge (In yrs. last	1	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day, Sept 7,	Year)	VI col	hplace (State or untry)	D.C.
	Director		5/9-32-6094	W 201	79	Yrs.					sept /,	1927	wasi	nington	ВС
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	hanyla		MD Montgome	ry	Ke	nsin	gton							1 ☐ Yes	2√ No
	28a-	ect	10e. Street and Number				10f. Zip	Code			1	0g. Citizen o	f What Co	ountry?	
	with p o	<u> </u>	4107 Spruell Drive					208	395			USA			
	leath	Funeral Director	_	12. Was Deceden		13.	Was Deced	ient of Hi	spanic Orig	gin? (Spec	cify Yes or No- lican, etc.)	14. R	ace - Ame	erican Indian, e, etc.	
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Maryland 21215-0036	hould d Me mark matic	2	19a, Informant's Name/Relationship (Ty	pe, Print)		19b. Maili	ng Address	(Street	and Numbe	or or Rura	l Route Number	r, City or Tow	m, State, .	Zip Code)	
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ē,	s 1 end 2 should be filed within 72 hours efter death with the Marylan I Heatin and Mental Hygiene I Heatin and Mental Hygiene I them 27 is marked other than "natural", or items 23s or 28s-f show item 27 is marked other than "natural", or items the notified at other treumstic event, it a Medical Examinating the notified at		20a. Method of Disposition		com	e of Dispo	osition (Name	me of other place	ю)	D	ate	20c. Locatio	n - City or	Town, State	
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Baltimore,	permit. Pages 1 end 2. Department of Health a importent: if item 27 ie eny injury or other treughce.		21. Signature of Eureral Service Licens Ronald S	aden Di	rector							. Balt	imore	Street	
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			shock, or heart failure. List only o Immediate Cause (Final	ne cause on eacr	i iirie.									Onset and D	Death
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			30. Name and address of person who	sempleted cause	of death (Item 2	23a) (Type	e, Print)	-	300	02					
-			Linda Marie Bur	rell	Silv gistrar's Signatu	ver S	pring	3.,M). ZU9	UZ.					
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State of Maryland / Department of Health and Menta	l Hygien 	00	16
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			1 - State Registrar	,	Ce	rtificate of	Death	,	Reg. No.	000	30000
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7	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death	1	1	County of Death	
			Peninsula Region				lisbury			Nicomi	Co
	Funeral Director		421-30-7771	7. Age (In) XIM 2 F 75	rs. last birthday) Yrs.	Months Days		8. Date of Birl (Month, Da NOV • 1	7, 19	9. Birth Cou	place (State or Foreign ntry) Dama
	and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limits
	/anyl	ъ	VA Fairfax	c,	pringfie	1.4					1 ☐ Yes 2 X No
	the 28a-	Je C	10e. Street and Number	3	or mgi re	10f. Zip Code			10g. Citize	en of What Cou	ntry?
	3a or	Funeral Director	5637 Inverchapel I	₹₫.		22151			USA	on or mar 000	,.
	death me 2	Jera	11. Marital Status	12. Was Decedent Ever in		Was Decedent of I	Hispanic Origin? (S	Decify Yes or No		4. Race - Ameri	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 ie marked other than "naturel", or Iteme 23a or 28a-f ehow eny injury or other traumatic event, If a Medical Examinar must be notified at once.	by	1 ☐ Never Married 2 ② (Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1X Yes 2 □ No 19 If Yes, Give Year or Dates:	948	if Yes, specify Cub 1 ☐ Yes 2X☐ No	an, Mexican, Puèrti Specify:	o Rican, etc.)	5	Black, White, Spec <i>ify:</i> Whi	
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the d	eath. Do not ent	er the mode of dyn	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
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Division of Vital Records, P.O. Box	The law requires that the death certiticate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)	y		23	3d. Date of deliv Month	ery Day Year
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rds	w require been sig should b	edt						101	res 2 🖸	Ho 3 □ Prot	bably 4 Unknown
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<u> </u>	hysic lidre	၉	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	R/Outpatien	t 3 DOA	er: 4 Nursing H	ome 5 Resid	dence 6	□Other (Specil	(y)
ב	Ing P		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injur Wor	ry at rk?	28d. Describe h	now injury	occurred	
<u>s</u>	tend seath tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No				
Σ	atter of Direct	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office		City or Tow		Number or Rura	al Route Number,
	To the Hospital or Attending Physicien: The within 24 hours atter death. To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	sician: To the best of my iner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	n occurred at the tirvestigation, in my o	me, date and place, pinion, death occur	and due to the ored at the time, or	cause(s) a date and p	ind manner as s place, and due to	tated. o the cause(s)
	To th within To th compi	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
			/ Web.) 1			1+	50497			24106	
	5		30. Name and address of person who c		tem 23a) (Type,	Print)	- / /				
-			Christophen SNy des 31. Date filed (Month, Day, Year)	20 100 E	CARROL	1 Street	SAlish	iny Me	l 2	1801	
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		7.00	140 -61 0	2004							

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DANIEL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 20ay Month NOV -2006 ar **Physician** Audrey Norma Lawson 12:28 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Longview Nursing Home Manchester Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Julie | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Yea 9. Birthplace (State or Foreign Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax **Funeral** 10M 20F 213-16-3146 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Heatth and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other than "naturel", or items 23s or 28s-1 show treumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Sparks 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ā 2112 Abell Lane 21152 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ♣ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Office Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jay Milton Knight ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10/4 Minnetonka Rd., Severn, Md. 21144 John Jay Lawson - son permit. Pages 1 and Depertment of Heath Important: if item 27 eny injury or other tr 2005. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metro Crematory Nov. 30,2006 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) -22 Name and Address of Facility Cknardt Tuneral 3296 Charmil Dr. 21. Signature of Funeral Service Licensee Chapel P.A. Manchester, Hatt helles 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Chronic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physicien and hed for use es the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: tf yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 pronths? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an 1 Yes verel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a cal Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Medi 29c. License number 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier 11-30-06 D 51705 DR, Hestminster, MD 21157 30. Name and address of person who completed cause of death (Item 23a) (IN PANSURIYA 349 MOUN) ype, Print) malwom 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 3 0 2006 Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28, Month **Physician** EUNICE BARBARA CHAMBERLIN LUSTED 2006 November 8:27 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST. JOSEPH MEDICAL CENTER Baltimore County Towson If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🂢 F Director 543-44-8419 Jan 17, 1931 Iowa Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location ir than "natural", or Itams 23a or 28e-f ehow The Madical Examinar must be notified at 10d. Inside City Limits Maryland Baltimore County 1 Yes 2 No Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 6504 Crestwood Road Funerai HSA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married ☐Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Elementary Teacher Education permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 Is marked otherny injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alfred Bolton Chamberlin Eunice Gertrude Sherbon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6504 Crestwood Road, Baltimore, Maryland 21239
of Disposition (Name of Date 20c. Location - City or Town, State <u>Dr. Keith Lusted</u> (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 12/1/2006 Baltimore, Maryland 21. Signature of Foreral Service Licensee

Martin D. Hawson 2. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
65(0) York Road, Baltimore, Maryland 21212
Approxima 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovascular **Physician** HTTENIOSCLEPOTIC /Medical Examiner Sequentially list conditions, in any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Qualto (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the death certificate be executed the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? Certification: Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicido within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and atle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)18667 November 29,2006 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Trimble H:11 CT, Lutherville, MD 32. Registrar's Signature 0 Registrar

Hyahan Marki Mi	o No.			Print in Black ind				
Hyshon Marki Mo		For State	of Maryland / Depa		na Mental H	ygiene	2000	2006
	اـــــا	Registrar		tificate of Death		Reg	No. ZUUT	3800
Physicia		Decedent's Name (First, Middle,Las	t)			Date of Death Month	ay Year	3. Time of Death
Medical Exami		Hushon Mar	Ki McNai	1		November 2		0132 hrs
		4a. Facility Name (if not institution, giv	e street and number)		or Location of Death		4c County of Death	
		6924 Hawthorne Street		Kentland			Prince George	's
Funeral		5 Social Security Number 6. Se	7. Age (In yrs Ia				MM/DD/YYYY) 9 Birt	
Director		215-02-4405 1	M 2 F 30	Yrs Months Da	ays Hours Min.	Sept !	Foreign	untry) Λ / C
	F	Usual Residence of Decedent				DEDY,	7,11101-	11
any		10a State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
ž		MA P. C		ndover				1 Yes 2 No
Maryland 28a-f show	왕	10e Street and Number	erqus La	10f. Zip Code	**	10g	Citizen of What Coun	trv?
e Ma or 28	ie	21115 0	1					,
hours after death with the Maryland natural", or items 23a or 28a-f shov Examiner must be notified at once,	Funeral Director	<u> 7645 Swqル /</u> 11. Marital Status	lerrace	207			USA	and the Other
r death w	Je.	1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces?		an, Mexican, Puerto	Rican, etc.)	14 Race - Americ White, etc.	can Indian, 81ack,
or i	3		1 Yes 2 No				(2)	17
136 hin 72 hours after than "natural", edical Examine	<u>۾</u>		If Yes, Give Year or Dates:		o specify		,	ick_
hour	g	15. Decedent's Education (Specify or		16a. Decedent's Usual Occup during most of working li			6b. Kind of Business/Ir	ndustry
66 m 72	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		0		11 /	40
withi	Ĕ	11 / 1		(serveral)	orvirac	tor	Home Ir	uprovement
5-6 iled Hyg	Ö	17. Father's Name (First, Middle, Last)			18 Mother's Name	(First, Middle, Ma	iden Surname)	
121 I be f ental arrhee	a	momas Mcl	Vair III		BIENO	la doya	cer Willi	ams
houlk M M is m:	2	19a Informant's Name/Relationship (T	ype, Print) Mother	19b Mailing Address (Str	eet and Number or F	Rural Route Numbe	er, City or Town, State,	Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after men of Health and Mental Hygiene lant: If item 27 is marked other than "natural". or other transmutic event, the Medical Examiner.	1	Brenda Jack	12010 /	7645 Swa			dove/ 140	20785
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no haces		4 Donation 5 Other Specify.	Kellioval Ilolli State	w St John Ce	material 12	12/01	Made Com	atri Ma
artme ortan	ŀ	21 Signature of Funeral Service Licen		22. Name and Addre	ess of Facility	00+0000	Hassi's To	1000
Baltimore, MD 21215-0036 permit Pages I and 3 should be filed within 72 hou Department of Health and Mental Hygiene Important: If item 27 is marked other than "nat injury or other traumatic event, the Medical Ex		-004			, ,	210	Parry Y	MULLI HOING
Physician	\dashv	23a Part I. Enter the disease, or comp	lications that caused the death.		oters tow	r respiratory arrest	shock or heart	Approximate Interval
/Medical		failure. List only one cause on ea	ich line.					Between Onset and Death
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tox 68760, reath certificate be attending physic for use as the but		IF FEMALE.	23c. If yes, outcome of preg	nancy			23d. Date of delivery	
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sion ttend death death y the	aţie	2 Accident Pending		01211110	Yes 2 ✔ No			
or A or A or A or A or A in b	iji	3 Suicide 6 Could not	De l	ome, farm, street, factory, office	e building, etc.	28f. Location (Stre or Town, Stat	eet and Number or Rur	al Route Number, City
Divisior pital or Attent cours after death cral Director:	Certification:	4 V Homicide determine	(Specify) Townhouse	e /		6924 Hawthorne	Street, Kentland , I	Vid.
		29a Certifier 1 Certifying Physic	an: To the best of my knowled	ge, death occurred at the time,	date and place, and	due to the cause(s	s) and manner as starte	ed
Fo the Hos within 24 h To the Fun	Medical	one) Medical Examiner	On the basis of examination a	nd/or investigation, in my opini-	on, death occurred a	it the time, date an	d place, and due to the	e cause(s)
L ≫ F 8	Me	29b. Signature and title of certifier		29c. Lice	nse number	2	29d Date signed (Mon	th, Day. Year)
		XXIIXI	11	0.0	C.M.E.	1	November 28, 20	06
	- 1	30 Name and address of person who	completed cause of dooth (thom	23a)				
6			stant Medical Examiner		altimore MD 21	201		
		31. Date filed (Month, Day, Year)	32. egistrar's Signatu				·	
St Regist	~~~		106 Blown L	1. Sports				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State	of Marylar		artment <i>tificate</i>			Mental H	ygienez Reg. No.	006	38063
l	Physici		1. Decedent's Name (First, Middle, Anne E.		110					2. Date of D Month Novemb	Day	2006	3. Time of Death 11:00A ^M
	/Medio Examir		4a. Facility Name (If not institution, Pear Tree Assis	3	•		4b. City, To		ocation of De		4c. Co	ounty of Death	
	Funeral Director		215-10-9738	6. Sex 1□M 2√□F	7. Age (In yrs.	last birthday) 88 Yrs.	If Under 1 Months	Year Days	If Under 24 H Hours M	in. (Month, L	12 19	9. Birth Cou	place (State or Foreign ntry)
• Maryland • f • how	Director		Arundel	10c. Cit	ty, Town or Lo	cation	Pa	sadena				10d. Inside City Limits 1 ☐ Yes 2√☐ No	
	23a or 2		10e. Street and Number 21 Milburn Circ	cle			10f. Zip C		21122		10g. Citize	n of What Cou USA	ntry?
5-UUS6 72 hours efter dee	172 hours effer deeth with the Maryland *neturel; or iteme 23a or 28e-f ehow sidical Examination must be multified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed F	2 🔀 No live		Was Decede f Yes, specif I ☐ Yes 2		panic Origin? , Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)		. Race - Ameri Black, White, pecify: W	
0-6171	thin 72 e.	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	grade completed	(1-4or 5+)	(Give	DO NOT use	done du	iring most of v	working		of Business/Ir	ucation
yland 2	permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: if item 27 le marked other th any njury or other traumatic event. The ance.	To Be Co	17. Father's Name (First, Middle, L William C	,	ok		10			Name (First, Middl Will			ucation
e, mar	1 end 2 should Health and Me em 27 le mark ither traumation		19a. Informant's Name/Relationsh Stanley W. Myllo 20a. Method of Disposition				Milbur	n C	ircle,	Pasadena	, MD 2		
Saitimor	permit. Pages Dependent of Important: If it any injury or o		1 □XBurial 2 □ Cremation 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L	ecify)		. Carin	el Chu	er place Inch	Cem	:. ^{Dat} 01 2006 Stallir	Pasa	dena, M	Maryland
ñ	Per Dep Imp		23a. Part I. Enter the disease, or i	Male amplications that	caused try at	th. Do not enti						MD 21	orne, P.A. 122
8/60,	Physician /Medical Examiner the private of the policy of t	dical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	o (or as a consect of (or a)))).	U(juence of):							Interval Between Onset and Death Typax
O. Box 62	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregna birth 2 Feta gnant at time of d nown	ıl death 3 □	Ectopic pred				230	d. Date of deliv	ery Day Year
ras, r.	requires thet the een signed by th hould be detache	þ	Part II. Other significant condition	gnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use of 1 □ Yes 2 □ Not									
DIVISION OF VITAL RECORT To the Hospital or Attending Physician: The law requiring 24 hours effer death. To the Funerel Director: After this certificate hes beer completely filled in by the funeral director, page 2 shou	The lay	Completed					-			24a. Wa aut per 1 🗆 Yes	tormed?	24b. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available impletion of cause of
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	al or Attendi s efter death if Director: A od in by the fi	Certification:	2 Accident investigi 3 Suicide 6 Could not determine	M 1 □ Yes 2 □ No factory, office 28f. Location (Street and Number or Rural Route Number City or Town, State)				al Route Number,					
	the Hospit hin 24 hours the Funere npletely fille	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physicien: To the xaminer: On the and ma	best of my kno basis of examina nner stated.	owledge, death tion and/or inv	estigation, in	n my opi	nion, death oc	ace, and due to the	, date and pl	ace, and due t	o the cause(s)
	7 7 8		> Ellion	who completed cau	Le of death live	m 23a) (Type		D)	009Y	1	290. Date s	signed (Mahth, $28/0$)	Day, Year)
	Sta	ate	C11 12 10 1	aty und	1411 Begistrar's Signa	Medisa	Va	rk	Drive	blen	Bukn	el ma	1,2061
	Registr	rar	NOV 9 0	2000 4		H A	A AF a						

Months

10f. Zip Code

1 ☐ Yes 2 No

Days

State of Maryland / Department of Health and Mental Hygien [] [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 26, 2006 9:22 p McELVEEN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Owings Mills **Baltimore** Rosewood Center

Date of Birth (Month, Day, Year) Apr 22, 1940

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

So.Carolina

10g. Citizen of What Country?

Specify:

U.S.A

14. Race - American Indian, Black, White, etc.

None

Baltimore, Maryland

23d. Date of delivery

1 Tyes

Month

Approximate Interval Between Onset and Death

Hours

Months

Day

24b. Were autopsy findings available prior to completion of cause of death?

2□ No

Year

Black

If Under 1 Year | If Under 24 Hrs. | 8.

Baltimore

21218

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

Hours

Min

Physician /Medical Examiner

1 - For State Registrar

10a State

Maryland 10e. Street and Number

11. Marital Status

Director

Funeral

þ

DOUGLAS

5. Social Security Number

249-21-5229

1631 Chilton Street

1 X Never Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

10b. County

Usual Residence of Decedent

6. Sex

N/A

1 XM 2 □ F

Funeral Director death with the Maryland or 28e-f ehov the Medical Examiner must be notified at or Items 23a within 72 hours after "natural",

permit. Pages 1 and 2 should be filled within 7 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "n eny injury or other traumatic event, the Madde 2006.

Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records, P.O.

Physician /Medical Examiner

The law requires that the death certificate be executed burial-transit and attending physicien as the use for detached page 2 should be After this To the Hospitel or Attending efter death. the within 24 hours e To the Funeral C

Examine Physician/Medical þ Completed Be 2 Certification: Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Jay Lippman

NOV 3 0 2006

Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done di life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Never Worked 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hattie McElveen Blandin McElveen ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1631 Chilton Street Baltimore, Maryland 21218 William McElveen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/02/06 **Arbutus Memorial Park** 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Decubitus Ulcers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □ Yes 2 □ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

7. Age (In yrs. last birthday)

66

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:

Yrs

10c. City, Town or Location

28f. Location (Street and Number or Rural Route Number. City or Town, State) Manager of the cause (s) and manner as stated 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D25001 30. Name and ad rest of person who completed cause of death (Item 23a) (Type, Print) 200 Rosewood Lane, Owings Mills, Deser.

State

Registrar

32. Registrar's Signature

			1 - For State Registrar	State of N	Marylan		artment of H		and Men		iene	006	38065
			1. Decedent's Name (First, Middle,	, Last)						Date of Deat Month		Voor	3. Time of Death
	Physici /Medio		Roy O. Moor	re						ov. 16	Day 200	Year 6	4:00 PM
	Examir		4a. Facility Name (If not institution,	give street and number	er)		4b. City, Town, or	Location o	of Death		4c. Cou	unty of Death	ר
				aks Nursing			Clinton						George's
	Funeral			6. Sex 7. / 112 M 2 ☐ F	Age (In yrs. I 90	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth Month, Day,			nplace (State or Foreign untry)
	Director		577 07 9754 Usual Residence of Decedent	Λ	90	113.			F∈	b 26,	1916	Mar	yland
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	Mar	tor	Maryland Prince	e George's		For	restville	:					1 □ Yes 2 □ No
	or 28	lre	10e. Street and Number				10f. Zip Code	,,,,,,		1	0g. Citizen	of What Co	untry?
	23a	Funeral Director	3506 South 1	Forest Edge	Road		207	47			Uni	ted St	ates
	ten de	Tue	11. Marital Status	12. Was Deceder Armed Force	s?	S. 13. V	Was Decedent of H I Yes, specify Cuba	ispanic Orig ın, Mexican	gin? (Specify , Puerto Rica	Yes or No- in, etc.)		Race - Amer Black, White	
36	s afte	by F	1 Never Married 2 Marrie 3 Widowed 4 Divorced	ed 1 Tes 27 If Yes, Give Year or Dates			1 ☐ Yes 2√√√No	Specify:			Spe	ecify: Wh	ite
8	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-f ehow he Medical Examiner must be notified at	ed	15. Decedent		s.	16a Decer	dent's Usual Occupa	ation			16b Kind o	of Business/I	
5	n n	plet	(Specify only highest	t grade completed)		(Give	kind of work done of	durina most	of working				st. of Heal
212	With a second	Completed	Elementary/Secondary (0-12)	College (1-4o	or 5+)	Lab '	Гесh			1	M.I.H		
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23s or 28s-1 show other traumatic event. I'm Medical Examinar must be notified at	Bec	17. Father's Name (First, Middle, L	.ast)				18. Mothe	r's Name (Fil	rst, Middle, M	Maiden Sur	name)	
<u>Ja</u>	Menti Menti arked	2	Harry Moore	<u> </u>				P	earl	Mayhe	N		
lar	2 sho and is m		19a. Informant's Name/Relationsh	- W			g Address (Street						
	end lealth m 27		Bessie E. Moore	e (Wife)	Ton. D	3506	South Fo	rest	Edge R	load, 1			, MD 20747
Baltimore,	ges to the Helphan		20a. Method of Disposition 1 DaBurial 2 Cremation	3 Removal from Sta	16		sition (Name of natory or other place		21,	100		on - City or 1	
ţ	t. Pa tmen tant: jury		4 □ Donation 5 □ Other (Sp		Foi		coln Ceme						Maryland
Bal	permit. Pages 'Department of H Important: If Ite any injury or ot		21. Signature of Funeral Service L	1-11	200.20		Name and Address lexandria						
			23a. Part1. Enter the disease, or o		MOI Z8	_						207	Approximate
	No.		shock, or heart lailure. List of immediate Cause (Final	only one cause on each	n line.			-		spiratory arre	331,	- 93	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Heart Disease Due to (or as a consequence of):										
	Examiner			D 60 (0) 8	as a consequ	dence or);							
		ē	Sequentially list conditions, I any, leading to immediate										
	outed d ansit	Examiner	Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	G									
ó	an ar	Ä	resulting in death) Last		as a consequ	uence of):							
8760,	The law requires that the death certificate be executed tte hes been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dlcal		d									
9	entific ing pl	Med	IF FEMALE:										
Вох	attending for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon	2 🗌 Fetal	death 3	Ectopic pregnancy				23d.	Date of delive	very Day Year
0.	the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant 9☐ Unknown		eath 5	Other (specify)						34,
Δ.	that the ed by th detach		Part II. Other significant condition	ns contributing to death	but not resu	alting in the ur	nderiving cause give	en in Part I.		23e. Did tob	acco use o	contribute to	the cause of death?
ds,	sign d be	d by				•	, , , , , , , , , , , , , , , , , , ,			1 □ Ye	2-43		
Record	w requir been si should	Completed								24a. Was a			Inna, findings available
Re	The lav	E								autops perform	y	prior to co	opsy findings available ompletion of cause of
<u>a</u>		ပို	25. Was case referred to medical					00 Di		1 ☐ Yes 2	2 No	1 🗆 Yes	2 No
of Vital	Physicien: this certific al director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa	atient 2 🗆	ER/Outpatien	t 3 DOA Othe	00	of Death (Ct rsing Home			Other /Snec	.6.1
0			27. Manner of Death	28a. Date of Ir	njury	28b. Time of	28c. Injun	at /		Describe ho			119)
Division	Attending Indeath.	Certification:	1 Natural 5 Pending 2 Accident investiga		Day Year)	Injury	World 1 □	k? Yes 2 □ N	No				
Vis		t t	3 ☐ Suicide 6 ☐ Could not determine	ned 288. Place of	Injury - At ho etc. (Specify	me, larm, str	eet, lactory, office		281.	Location (St. City or Town	reet and Nu	mber or Rui	ral Route Number,
	spital or A ours after nerel Dire filled in by	Cer		, , , , , , , , , , , , , , , , , , ,		,					. 0.0.0,		
	• Hospital 24 hours • Funerel letely filled	cal	29a. Certifier 1 Certifying (Check only 2 Medical E	g Physician: To the be Examiner: On the basis	st of my know	wledge, death	occurred at the time	ne, date and	d place, and o	due to the ca	ause(s) and	manner as	stated.
	To the Hos within 24 h To the Fun completely	Medical	one)	and manner	stated.								
	S S S		29b. Signature and title of certifier	<i>(</i>) -			29c. License	number		2	Jate sk	gned (Month	. Day, rear)
,	7		Willia V	come m			1)36	WY			NE	Van V	7 17, 206
(1	7 "		30. Name and address of person v	no completed cause of	t death (Item	23a) (Type,	Print)	Lu. V	Bud &	Fort 1	WASH I	instor	mountant
Ų.	Sta	te	31. Date filed (Month, Day, Year)	32. R/60	strar's Signat	ture	1 1000		UR 1			1,	
	Registr		NOV 3	0 2006	ENSO.	A. A.	parel						Day, Year) 17. 2wb 2. Mary/ml

DHMH 17 Rev 1/2001

State Registrar 31. Date fifed (Mor

Mullings, M

gistrar's Signature

maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38067 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 21,2006 November 12:43P M Shirley | J. Morris 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 5907 Sylvia Ct. Clinton 8. Date of Birth (Month, Day, Year) April 25, 1939 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 □ M 459 62 5953 67 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □ Yes 2□ No Maryland Prince George's Clinton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5907 Sylvia Court 20735 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ∏ No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Retired Transporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William E. Menkemeller Eileen Kennen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5907 Sylvia Court, Clinton, MD 20735 Timothy Morris (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 27, 2006 20a. Method of Disposition 20c. Location - City or Town, State 1 \(\mathbb{K} \) Eurial 2 \(\subseteq \text{Cremation} \) 3 \(\subseteq \text{Removal from State} \) 4 \(\subseteq \text{Donation} \) 5 \(\subseteq \text{Other} \) (Specify) Waldorf, MD Trinity Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 200153 w Alexandria Ferry Rd, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HIGH disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes

Physician /Medical Examiner

and

Physician

/Medical

Examiner

Director

Funeral

<u>۾</u>

Completed

Be

Funeral

Director

2 should be filed within 72 hours after death with the Maryland I and Mental Hyglene. I show fis marked other than "natural"; or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Pages 1 and 2 should

item 27 is

permit. Pages 1 Department of the Important: If ite any Injury or ot

or other

as the burial-transit ed by the attending physician detached for use as the buria Certification:

Examiner Physician/Medical Completed P

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown

> 24a. Was an 1□ Yes 2 100 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 21 No 1 ☐ Yes 27. Mann of Death 1 Natural 2 Accident

29b. Signature and title of certifier

Madhu Mohan, 31. Date filed (Month, Day, Year)

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

and manner stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

11/22/06

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

29c. License number 29d. Date signed (Month, Day, Year)

DOD 23125

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9560 Pennsylvania Ave. #202 Upper Marlboro, Md. 20772

State Registrar

Medical



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Division or Vital Records, P.O. Box 68760,

the death certificate be executed

To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or

DHMH 17 Rev 1/2001

this

State of Maryland / Department of Health and Mental Hygiene 38068 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28, 2006 **Physician** November 7:15P M JANET LEE MARRI F /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 416 Cedarcroft Road N/A Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year) June 24, 1945 9. Birthplace (State or Foreign **Funeral** 210-34-6079 1□ M **X**2**X**1 F Pennsylvania Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits **ehow** r than "naturel", or items 23a or 28a-1 ehov the Medical Examinar must be notified at XX Yes 2□No **Funeral Director** Massachusetts Norfolk Newton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 02461 USA 85 Charlemont Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ State of Massachusetts Social Worker permit. Pages 1 end 2 should be filed v Depertment of Health and Mental Hygien Important: if Item 27 is marked other th eny injury or other traumatic event, IIIA ODG. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Walter Samuel Trapp Virginia Randolph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 85 Charlemont Street Newton Massachusetts 02461 Paul W Marble Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2XXCremation 3 ☐ Removal from State GreenMount Crematory 11/30/06 Baltimore, Maryland 4. □ Donation 5 □ Other (Specify) gnature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** years /Medical Due to (or as a consequence of): Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as i signed by the ettending I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 I Hoknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 1 ☐ Yes 2∏ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 515+655 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: / 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by 4 ☐ Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of confifier 29d. Date signed (Month, Dey, Year) 29c. License number 29/06 D0056919 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medan 32 Registrar's Signature 31. Date filed (Month, Day, Year) State The Best San NOV 3 0 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 12 per fh 2861 11-30-06 vt
State of Maryland / Department of Health and Mental Hygiene
1- State Amend item#20b-c, perFh, C862, 12/6/06 TT
Reg. No.- 0 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day خارگ **Physician** Month Year a Mes Owens 9:29PM 2006 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceneul Hospital Maryland HIMRE a If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 1 M 2 ☐ F 214-56-5315 Yrs. 52 Director 109/1954 MAR VLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show Examiner must be notified at 1ÆYes 2☐No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes Extro If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 █ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Monce. 10 HIGRADE STRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (MES ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SISTE ATONSVILLE 20a. Method of Disposition 0b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 Removal from State /6/2006 Woodlawn, MD 4 Donation 5 Dother (Specify) WNSVILLE ress of Facility BROWN TR. 21. Signature of Funeral Service Licensee FUNERAL MO.2121 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or res in tory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** TOR /Medical Due to (or as a consequence of): **Examiner** So pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran To the Hospital or Attending Physician: The law requires that the death certificate be execu physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Donknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy his certificate ha performed 1☐ Yes 20 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death

1 Natural

2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Offector;
completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Oli mirebrahim MD cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State NOV 3 0 2006 Registrar

6-09083		Please Type or Print in Bl				
lorence Rober	ta P	otalio of maryland / Dopartment of t		ygiene	000	
		Registrar Certificate of L	Death		eg. No. 200	<u>6 3807</u>
Physici Medical Exam		1 Decedent's Name (First, Middle Last)		 Date of Deat Month 	Day Year	3 Time of Death
		4a Facility Name (if not institution, give street and number) 4b.	City, Town, or Location of Death	November	24, 2006 4c County of Death	1150 hrs
			Fowson		Baltimore Cou	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	8. Date of Bir	th(MM/DD/YYYY) 9 Bir	
Director		218-68-5255 1 M 2 F 82 Yrs.	Months Days Hours Min.	٦,	Foreig	
		Usual Residence of Decedent		May 2	6,14,4	Ma
, any		10a. State 10b. County 10c. City, Town or Location		-		10d Inside City Limits
Maryland 28a-f show d at once.	ō	Md N/A Baltimore				1 / Yes 2 No
Mary - 28a-	Director	10e. Street and Number	Of, Zip Code	10	Og Citizen of What Cour	ntry?
th the M 23a or 2 notified		412 Fairmount Ave 21286	21286		USA	
ith wi lems ;	Funeral		ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc	can Indian, 8lack,
er dea		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	es 2 No specify		Specify B	10
5-0036 led within 72 hours after death with the Maryland tygene other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	d b	or Dates:	Usual Occupation (Give kind of w	vork done	16b. Kind of Business/I	ndustry
72 hor	Completed		of working life. DO NOT use retir			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
)036 within 72 iene er than *	фш	7th Dom	ustic		Own Hom	e
5-0 iled w Hygid I othe	ပိ	17. Father's Name (First, Middle, Last)	18.Mother's Name		Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene marked other thau event, the Medica	Be	John Pinkney	Floren	Ce		
MD 2 id 2 shoul olth and N m 27 is m	٩		ddress (Street and Number or R		Α	
e, ML and 2 s Health a item 27	-	20a. Method of Disposition 20b. Place of Disposition		Date	20c. Location - City or	Q Q Town State
of I		Burial 2 Cremation 3 Removal from State crematory or other	place)			
트 교 및 등 근.	ŀ	4 Donation 5 Other Specify 21. Signature of Spineral Service Licensee 22. Nam	e and Address of Facility	-2-00	10WSON /	Ma.
Balt permit Depart Import		Lerry Havis 524	0			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the n failure. List only one cause on each line	node of dying, such as cardiac or	r respiratory arre	est. shock, or heart	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease a Left femoral fracture comp	licating atheroscle	erotic ca	rdiovascular	Between Onset and Death
)		or condition resulting in death) Due to (or as a consequence of): nisease				
	ᆲ	Sequentially list conditions, if any, leading to transdicts Due to (or as a consequence of):				
	nin	C				
rd sit	Examine	events resulting in death) Last Due to (or as a consequence of):				
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	dical E	X UNPENDED X AMENDED #23a,PII,27,28a-f,	por ME 2962 12/	21 /06 1111		
e be e	edi	#10e_pertH_(-861_1	1/30/06 TT	21/00 11	#28a, perME,	2866,4/3/07 T
Box 68760 e death certificate be the attending physical for use as the bu	N/S	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal of	death 3 Ectopic pregnar	ncy	23d Date of delivery Month D	ay Year
X 6 th cer trendi	icia	4 Pregnant at time of death 5 Other	(Specify)	,	_	-,
BC ne dea t the a	Physician/Me	1 Yes 2 ✓ No 9 Unknown 9 Unknown				
ires that the d signed by the		Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I		bacco use contribute to t	
S, quires en sig	Completed by	Cerebral infarcts ; diabetes mellitus		1 Yes		ably 4 V Unknown
cords aw requi as been 2 should	el di			autops perforr	sy prior to co	opsy findings available ompletion of cause of
Rec The I	등			1 Yes 2		2 No
cians certif	Be	25. Was case referred to medical examiner?	26.Place of Death (Check of Door Other Nursing			
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	의	1 Yes 2 No			Residence 6 🗸 Other:	Scene
n of inding Ph. After 1 function	ē	27. Manner of Death 1 Natural 5 Pending 28a Date of Injury 28b. Time of Injury 1 1 4 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	1 Yes 2 VNo		ow injury occurred	
ision Attencer death rector: by the	icat	2 X Accident Investigation 28e Place of Injury At home form street for		subject f	treet and Number or Rur.	al Bouto Number City
Divi	ertification;	determined (Specific) Managing home		or Town, St. Towson, M	ate) 509 E. joppa	a Road
Hospi 24 hou Funer ely fil	아	4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred (check only 1				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated				
	Ne.	29b Signature and title of certifier	29c. License number		29d Date signed (Moni	th, Day, Year)
10/5		and I	O.C.M.E.		November 29, 20	06
perd		30. Name and address of person who completed cause of death (Item 23a)	<u> </u>			
			et, Baltimore, MD 21201			
St Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
DHMH 17 Rev 1/2						
OCME 2006	TUU	OŘIGINAL				

			1 = For State Registrar	ate of Marylan		artment of Hea rtificate of De		ental Hy	giene 006	38071
Ţ,	Physici	ş an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	aath , Day Yea	3. Time of Death
1	/Medic		JAMES E. PRIN			T		Novem	1,	
-2.	Examin	ier	4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or Loc	cation of Death		4c. County of D	
341	5		903 WOODBRIDGE CT # 5. Social Security Number 6. Sex	T. Age (In yrs.	last birthday)	EDGEWOOD If Under 1 Year If	Under 24 Hrs.	8. Date of Bir	HARFO	Birthplace (State or Foreign
	Funeral Director		214-30-5979	2∏ F	7 4 Yrs.	Months Days H	lours Min.	(Month, Da	ay, rear)	Country) MARYLAND
40	P. J.		Usual Residence of Decedent							
	anyla shov	٦.	10a, State 10b. County	Toc. Cit	y, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 XNo
	the M	Director	MARYLAND HARFORD C	0		EDGEWOOD 10f. Zip Code			10g. Citizen of What	
	death with the Maryland ms 23a or 28s-1 show		903 WOODBRIDGE CT	#E		21040		İ	U.S.A	-
	ms 2	Funeral	11. Marital Status 12. V	as Decedent Ever in U	.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N	nic Origin? (Spec	rfy Yes or No		merican Indian,
5-0036	be filed within 72 hours after death with the Marylan Hygiene. I allygiene. I other than "natural", or liems 23a or 28s-f show event. The Madical Examiner must be notified at	þ	1 Never Married 2 Married 1	med Forces? XIXes 2 □ No Yes, Give ear or Dates: 53/5			Specify:	iican, etc.)	Specify: B	
	"natu	Completed	15. Decedent's Education (Specify only highest grade con	n npleted)	(Give	dent's Usual Occupation kind of work done during	n ng most of workin	g	16b. Kind of Busine	ss/Industry
7	within 72 ene. than "na he Medic	E G		ollege (1-4or 5+)		DO NOT use retired)	MOD.		BALTIMORI	E COLINEY
.74	filed Hygid other		7th grade 17. Father's Name (First, Middle, Last)		EQUIE	PMENT OPERA 18.		(First, Middle	, Maiden Sumame)	E COONII
land	lid be lental rked o	To Be	WILLIAM E PRINGLE				MARY LE	ONARD		
Mary	es 1 and 2 should bot Health and Ment 1 feet 27 ie marked r other traumatice		19a. Informant's Name/Relationship (Type, F	rint)	19b. Maili	ng Address (Street and	Number or Rural	Route Numb	er, City or Town, Stat	e, Zip Code)
e) G	and 2 Balth n 27		Sarah Pringle/Wife							cyland 21040
ore	Pages 1 nent of Ho int: if iter iry or oth		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Remove		Place of Dispo cemetery, crea	osition (Name of matory or other place)	Da	rte	20c. Location - City	or Town, State
aitimor	tmen tant:		4 □Donation 5 □Other (Specify)	DUI	LANEY V		11-30		TIMONIUM,	
g n	permit. Pages Department of the important: if ite ony injury or of once.		21. Signature o Pun S se i 56							arford, P.A.
41	* * *		23a. Pa 11 Enter the disease, or complication	ns that caused the deat		321 S PHILA ter the mode of dying, si				Approximate
*	Physician		shock, or heart failure. List only one ca Immediate Cause (Final	use on each line.	. 1:	4				Interval Between Onset and Death
45	/Medical		disease or condition resulting in death)	Due to (or as a conseq		a				years
	Examiner		Sequentially list conditions b. —							
-	ecuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a conseq						
8/60,	centificate be executed nding physician and use as the burial-transit	dical Ex	resulting in death) Last	Due to (or as a conseq	uence of):					
õ	artifica ing pl	Med	IF FEMALE:							
ň	atter for u	Physician/Me	in the past 12 months?	yes, outcome of pregna □Live birth 2 □ Feta □ Pregnant at time of d □ Unknown	death 3	Ectopic pregnancy Other (specify)		-	23d. Date of Month	delivery Day Year
7	s that ned b	by Pt	Part II. Other significant conditions contribu	ting to death but not res	ulting in the u	inderlying cause given in	n Part I.	23e. Did	tobacco use contribute	e to the cause of death?
Hecords	w requires that the de been signed by the should be detached					<u> </u>		1 🗆	Yes 2□No 3□	Probably 4 Unknown
ပ္မ	lawre asbe	Completed						24a. Was	an 24b. Were	autopsy findings available to completion of cause of
-	ician: The lav certificate has rector, page 2.	Co						perfo	orm 2 death	i? 'es 2□ No
Vitai	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	al:		7 -	S. Place of Death	2000	11000	
_	<u>×</u> ∞ 5	. To	1 162 5 V 140	a. Date of Injury	ER/Outpatier 28b. Time o				idence 6 Other (S	pecify)
0	ding th.	tlon	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	Work?	2 □No	og. Doscribo	now injury occurred	
JIVISION	Atten r deal ector by the	Illca	3 Could not be	e. Place of Injury - At h	ome, farm, st				Street and Number or	Rural Route Number,
5	tal or is afte al Dir	Certification:	4 Homicide	building, etc. (Specif	γ)			City or 10	wn, State)	
	To the Hospital or Attanding Ph within 24 hours ditted death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physicial Medical Examiner:	n: To the best of my kno On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the time, ovestigation, in my opinion	date and place, ar on, death occurre	nd due to the d at the time,	cause(s) and manner date and place, and o	as stated. due to the cause(s)
•	To t To t	Σ	29b. Signature and fittle of certifier	D		29c. License nu	3/4		29d. Date signed (Ma	onth, Day, Year)
(otl		30. Name and address of person who completed from the form that the form the form that the form that the form that the form	ted cause of death (Item	47	Print)	R. /	CT 4	= 1kTon	hu 27, 2006
	Sta	ate	31. Date filed (Month, Day, Year)	32. Pogistrar's Signa	iture	1	2	11		200
*	Registr		NOV 3 0 2006	Been	K A	ast .				
DHN	/IH 17 Rev 1/2	001			ORIGIN	MΔI				
					1110/11	4 / 1 has				

			Flease	Obber (Marilan			_	_			
		1	For State	State of Marylan	d / Department of Certificate o		ental Hygler Reg. I	ZUUb	38072		
			Registrar 1. Decedent's Name (First, Middle, Las.	1)		, Dodi.,	2. Date of Death	10.	3. Time of Death		
	Physicia	an	C-ENEVA	,	PARK	<	November	Day Year 200	16 100 AM		
	/Medic Examin		4a. Facility Name (If not institution, give	street and number) APT	: 13 4b. City, Town	, or Location of Death		4c. County of Deal			
	Examin	er	6982 Milhon	OK Park Dr	ive Ba	Himore		N	'/A		
* <u>*</u>	Funeral		Social Security Number 6. S		last birthday) If Under 1 Ye Months Day	ar If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Bin	hplace (State or Foreign ountry)		
	Director		249-52-1774	M 2 7	Yrs. Months Day	A Hours Will.	MARCH 18,1	932 50			
2			Usual Residence of Decedent	10- 69	T		/		10d. fnside City Limits		
relate	show	_	10a. State 10b. County	Toc. Cit	ty, Town or Location		11		1 ✓ Yes 2 ☐ No		
Ž	Ba-f	Director	MATKYLAND NI	A		LTIMORE		Citizen of What Co			
with the Maryland	23a or 28a-f shov		10e. Strefet and Number	Deal Dague	10f. Zip Cod	240 1	710g.	USA.	ountry :		
death	a 23,	Funeral	67821916	12. Was Decedent Ever in U	S 13 Was Decedent	of Hispanic Origin? (Spe	ocify Yes or No-	14. Race - Ame	encan Indian.		
, a	item	Ë	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 Yes 2 XNo	If Yes, specify C	of Hispanic Origin? (Spe uban, Mexican, Puerto	Rican, etc.)	Black, Whit			
-0036	P. Or	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Yes 2 💢 I	No Specify:		Specify: 3	ACK		
5 2	atura Gal	Completed	15. Decedent's Ed	ucation	16a. Decedent's Usual Oc	cupation ne during most of worki	16b	. Kind of Business	Industry		
1215-	. E. M	ple	(Specify only highest grade Elementary/Secondary (0-12)	Coflege (1-4or 5+)	life. DO NOT use re	ired)	9	,	α		
		On	12+HGRADE		JALES,	FERSON	13.	EAUTY SU	PPLY CO.		
and 2	al Hy	Be (17. Father's Name (First, Middle, Last)		14 = 0	18. Mother's Name	(First, Middle, Maid	den Surnafne)	0 =:		
<u>Z</u>	Ment	ဥ	HENRY		KER	MARY	DELL	MOO.	RE		
Mary	and is m raum	1	19a. Informant's Na Relationship (7	ype, Print)	19b. Mailing Address (Str						
	fealth im 27 her t		NATITANIEL PARKS	JK (HUSBAND)	Place of Disposition (Name of	ROOK PARK	DE APT, 10	. Location - City or	MD . 2/2/5		
mor	or of		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	cemetery, crematory or other	place)					
altimore,	rtant		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		AKKISON FOR	EST 12-0 dress of Facility 2/5	1-06 00	UNGO 19	TLLS 190,		
Ba	Depa impo any i		21. Signature by Pullerar Service Ciceri	11. 11 2000	ima Tosani	11 Bm.	TI	amil H	me 21217		
			23a. Part1. Enter the disease, or comp	olications that caused the deal	th. Do not enter the mode of	dying, such as cardiac of		eral 12	Approximate Interval Between		
D	byoioion	Ì	Immediate Cause (Final								
	hysician /Medical		disease or condition resulting in death)	na	6770000						
E	xaminer		PARTICIPATION OF THE PROPERTY								
		ner	Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						
1/2	nd trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last								
60, E	sicien and burial-transit										
- 0		dlcal		d							
9 X	ding	/Me	IF FEMALE:	23c. ff yes, outcome of pregn	ancy			23d. Date of de	livery		
Вох	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	incy		Month Day Year				
P.O.	y the	lsku	1 ☐ Yes 2 ☑ Aleo 9 ☐ Unknown	9□ Unknown							
ر و	been signed by the should be detached	by Physician/Medi	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the underlying cause	given in Part I.	23e. Did tobacc	co use contribute t	o the cause of death?		
rds	an sig	ed E					1 🗆 Yes	2 □ No 3 1 P	robably 4 □Unknown		
00	s be	plet					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of		
œ j	ete hes	Completed					performed 1 ☐ Yes 2	l? death?	-0		
ita	ctor,	Be	25. Was case referred to medical examiner?				(Check only one)				
<u> </u>	his co	P	1 ☐ Yes 2 ZNo		E-Voulpatient 30 DOA		me 5 Residence		ecify)		
בו	After 1	ü	27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		Work?	28d. Describe how i	njury occurred			
Sic	death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	9 290 Place of Injury - At h	M Morne, farm, street, factory, off	1 ☐ Yes 2 ☐ No	28f. Location (Stree	t and Number or R	ural Route Number		
Division of Vital Records,	after Direct	Certification:	4 Homicide determined	building, etc. (Speci	ify)		City or Town, S				
_	24 hours a Funeral C	a C		ysician: To the best of my kn							
Division of Vital Records, P.O. Box 68	within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical Examone)	niner: On the basis of examin and manner stated.	ation and/or investigation, in r	ny opinion, death occurr					
3	within 2 To the	Σ	29b. Signature and title of certifier			Pense number 0276	29d.	Date signed (Mon	th, Day, Year)		
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,	j		Dans	" Mar					,		
,	N.		30. Name and address of person who	4	m 23a) (Type, Print)		RH	1	20000		
,	Ţ,	ate	.A - A. 11	4	m 23a) (Type, Print) he ch Rave	0 /	Ba H	imore, b	7,2006 rd 21239		

			1 - For State Registrar	State of M	laryland		artmen rtificat					giena Reg. No.	006	3807	13
1 10		ψ.	Decedent's Name (First, Middle, Last	st)							2. Date of De	ath Day	Year	3. Time of De	ath
	Physicia /Medic			George F	. Peo	ples					Novemb				MM
	Examin		4a. Facility Name (If not institution, give			•	4b. City,	Town, or	Location	of Death		4c.	County of De	ath	
		, the	Manor Care						Bethe					tgomery	
. 5	Funeral		Social Security Number 6. S	ex 7. Ag 1X M 2 ☐ F	ge (in yrs. la	ast birthday Yrs.	/ Il Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	iy, Year)		irthplace (State or Fo Country)	oreign
4.)	Director	-	556-26-6462 Usual Residence of Decedent	25	83	115.					Februar	y 2,19	923	Oregon	
	and and		10a. State 10b. County		10c. City	, Town or L	ocation							10d. Inside City L	_imits
	Many feb	ŏ	Maryland Monte	omery					Bethe	a d a				1 □ Yes 2	X No
	288 10011	Directo	10e. Street and Number	Omery			10f. Zip		betne	Sua		10g. Citiz	en of What (Country?	
	death with the Maryland ma 23a or 28a-f ehow Imust be notified at		5602 01	nwood Roa	, d				2081	7			Unite	d States	
	ma 2	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.	S. 13	Was Dece	dent of H			ecify Yes or No Rican, etc.))- 1		nerican Indian,	
0	arrer or its	Ē	1 ☐ Never Married 2 X Married	Armed Forces 1 X Yes 2 ☐ If Yes, Give			1 Yes				rican, etc.)		Specify:	ше, ес.	
0500-c	hours affer turei', or its	d by	3 Widowed 4 Divorced	Year or Dates:	1942-	1974	103	2440	opecny.					White	
'n	72 h	Completed	15. Decedent's Ed (Specify only highest gra			(Giv	edent's Usu e kind of wo	rk done	durina mos	st of work	ng	16b. Kir	nd of Busines	s/Industry	
Z	within ene. than "	Idm I	Elementary/Secondary (0-12)	College (1-4or	5+)	iife.	DO NOT u		*			11-	المسائم	Ctotos Nor	
A	e filed within al Hygiene. I other then "		17. Father's Name (First, Middle, Last,	5+				Offi		er's Name	(First, Middle			States Nav	VУ
=	ntal h	Be													
	hould d Mer marke matic	ဥ	19a. Informant's Name/Relationship (igh People Type Print)	es	19h Mai	ling Address	(Street	and Numb	er or Rura	Lea Il Route Numb	ah Gr er. City oi		. Zip Code)	
2	and 2 sealth and 2 smulth and 27 ionner traus		Winifred D. Peo		- 0		-							nd 20817	
စ်	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. I important: if fine 27 is marked other than "naturel", or itama 23e or 28e-1 show eny injury or other traumatic event, the Medical Examinational Confidence on once.		20a. Method ol Disposition	opies/ Wil	20b. P	lace of Disp	osition (Na	ne of			Date			or Town, State	
	ages ant of it: if i		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		9	Aı Natior	lingt	on	1	Jan	uary 2007	Λ ~	lingt	on, Virgir	กร่อ
	artme ortan injur		21. Signature of Fugeral Service Licer		<u> </u>	vacioi	22. Name ar	nd Addre	ss of Facil	ity Rob	ert_A.	Pump	hrey I	uneral Ho consin Ave	me/
ğ	ony one			C./1	M003	135 E	ethes	da-C da M	hevy arvla	Chas	e, Inc. 0814-3	. 755 501	7 Wisc	onsin Ave	nue
		П	23a. Part1. Enter the disease, or con	plications that cause	d the death	n. Donote	nter the mod	te of dyin	ng, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between	en
В	Physician	- (1	shock, or heart failure. List only Immediate Cause (Final			T	_ * *							Onset and Dea	
,	/Medical		disease or condition resulting in death)	a. Myocar Due to (or a			ction		-					l Hour	
	Examiner		a de la Francisco de la Companya de	b. Athero	scler	otic	Heart	Dis	ease					Years	
Þ		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a											
	acufec nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C											
Ď,	ate be executed hysician and the burial-transit		resulting in death) cast	Due to (or a	s a consequ	uence ol):									
8/60	ate b	dlcal	•	d								-			
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XOR	affen for us	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal	death 3	☐Ectopic p		/			4	Month	Day Yea	ar
o.	by the destached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	at time of di	outi o	_ Other (s)) — () — (-					
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	sician: The law certificate has t irector, page 2 s	mc										ormed?	prior t death	o completion of caus ?	se ol
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0	ig Phys ter this neral di		27. Manner of Death	28a. Date of In (Month, D	jury Jay Yearl	28b. Time Injury	of	28c. Injui			28d. Describe				
Division of Vital R	ttending I death. ctor: After y the funer	atlo	1 Natural 5 Pending 2 Accident investigation		, , , , , ,	ii ijai y	м		Yes 2]No					
<u> </u>	r Atte	Certification:	3 Suicide 6 Could not be determined	286. Place of I	njury - At ho		street, factor	y, office				Street and		Rural Route Number	Γ,
Ξ	taiol rsaff al Di led in	Cer													
	t hour tuner	edical	29a. Certifier 1 Certifying P	nysician: To the bes miner: On the basis	st of my kno of examina	wledge, de	ath occurred	at the til	me, date a	nd place, ath occur	and due to the	cause(s) date and	and manner place, and d	as stated. ue to the cause(s)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medi	one)	and manner					se number					nth, Day, Year)	
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-	107		30. Name and address of person who					1 "	200	0-1-	1 1		To	J 20070 C	2601
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5. Social Security 212-44	1.5	x 7. Ag □M 2፟∭ F	e (In yrs. Ia:	Yrs.	Months Days		Min.		Day, Year)	9. Bi	irthplace (State or Country) DC	Foreign
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											10d. Inside City 1 ☐XYes	
			Dal	CIMOL					10g. Cit	izen of What (
767 Ch	aring Cr	oss Road			,	229			*		•	
				13. W			origin? (Speci	fy Yes or N		14. Race - Am	nerican Indian,	
	_	1 Yes 201 If Yes, Give Year or Dates:	No					can, etc.)				
(Spe	15. Decedent's Ed ecify only highest grad	ucation de completed)		16a. Decede	nt's Usual Occu	pation during mo	ost of working		16b. K	ind of Busines	s/Industry	
12th ar	condary (0-12) ade		5+)						Bar	nk of	America	a n
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Vernon	Proctor	-Husband			Section of the second	g Cr			Bal	timor	e, Md 2	1229
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4 □ Donation	5 ☐ Other (Specify)	Met					4/06	В	altim	ore, Md	
21. Signatur vot i	A LOGA O	Pee 1	200	Ma.	rch F/	H We	st					
23a. Part1. Enter	the disease, or comp	lications that caused	the death.							e, Md	Approximate	
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disease or condit resulting in death	tion	a		-	31 171 1711	7	RNA	2/2 6	>////	070	1 1	OVR
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if any, leading to cause. Enter Uni	immediate derlying		a conseque	ince of):								
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	ent pregnant				etopio prognanc					23d. Date of d	elivery	
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Part II. Other sign				ing in the uni	leriying cause gi	ven in Par	t I.					
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								aut	opsy	24b. Were a prior to death?	autopsy findings a completion of ca	variable use of
25 Was case ref	erred to medical							1 Yes	2. No			
examiner?		Hospital:	ent 2	B/Outpatient	3 DOA Ot					6 □Other (Sn	agosfu)	
27. Manner of De	ath			8b. Time of								
2 Accident	investigation		y / Oui,	mjury			□No					
	dotominad	286. Place of Inj	ury - At horr c. (Specify)	e, farm, stre	et, factory, office		28	f. Location City or T	(Street an	nd Number or F	Rural Route Numb	9e <i>r</i> ,
						- CONTRACT					A Lawrence	
(Check only	1 Certifying Ph 2 Medical Exam	i iner: On the basis o	f examination	ledge death on and/or inve	occumed at the testigation, in my	ima, data : opinion, de	and place, an eath occurred	d due to the at the time	e dausa(s) e, date and) and manner (d place, and di	as stated: ue to the cause(s)	
	nd title of certifier	and mainer su	a160.		29c. Licen	se number	r		29d. Da	te signed (Mor	nth, Day, Year)	
1 1//	us lit	mo)		Do	051	865		N	Ovens	BER 26	2000
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Marchal Status	MD NA Baltimore 106, Sireet and Number 767 Charing Cross Road 12, 229 109, Cit 767 Charing Cross Road 12, 229 11, Marital Status 12 Was Decedent Ever in U.S. 13, Was Decedent of Happanic Origin? (Specify Yes or North American Puerfor Ricca, etc.) 11 Wes. Specify Colors Medican, Puerfor Ricca, etc.) 12 Was Decedent of Happanic Origin? (Specify Yes or North West Colors and Puerfor Ricca, etc.) 12 Was Decedent of Happanic Origin? 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Citzen of What Country T67 Charring Cross Road 21229 10g. Citzen of What Country T67 Charring Cross Road 21229 11. Martial Status 1. Whore Married 20 Married 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin' (Specify Year or No 1. Very RCI No 1. Very RC			

State of Maryland / Department of Health and Mental Hygien U U b For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Nov 28, 2006 Year **Physician** Yvonne Packard 6:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of 8 irth (Month, Day, Year) 5. Social Security Number 8 Sirthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 451 38 5662 77 Yrs Director April 13, 1929 Texas Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other then "naturel", or Items 23a or 28a-f show yent. The Medical Examinar must be notified at 1 Yes YZY No Maryland Prince George's Camp Springs Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6202 Joyce Drive 20748 United States filed within 72 hours after death 1 Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 8lack, White, etc. 11. Marital Status 1 Yes 2 XXIVO If Yes, Give Year or Dates: 0. 1 Never Married 27 Married 1 Yes 2/No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Own Home Homemaker permit. Pages 1 end 2 should be file.
Depertment of Health and Mental Hyg.
Important: if Item 27 le marked other
any injury or other treument. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Monroe Williams Vera Belle Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendell Packard (Wife) 6202 Joyce Drive, Camp Springs, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Nov 30, 2006 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 170015 3 Alexandria Ferry Road, Clinton, MD 23a. Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ances nno o months **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ng physiclen end as the burial-transit Due to (or as a consequence of): Physician/Medical signed by the attending of the deteched for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete hes autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending investigation м 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide To the Hospital within 24 hours of To the Funerel Completely filled Contrying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) 29c. License number 52741

J CAINE 11701 LIVINGSTM Rd FF Wushington

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

PANOLINE 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** MARVIN EARL RUFFIN 22:55 M NOV. 26 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GILCHRIST CENTER FOR HOSPICE TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 12/06/1953 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F 52 212-60-4578 Director CAROLINA N. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at N/A BALTIMORE CITY MD Director 1 □ X es 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 1701 MONTPELIER STREET USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽÜNo Specify: ۵ Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) SPARROWSPOINT Elementary/Secondary (0-12) 12TH College (1-4or 5+) CONSTRUCTION WORKER SHIPYARD CORP. h and Mental Hygie 7 is marked other to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARVIN RUFFIN ELOISE COLEY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traun 943 SOUTHRIDGE RD., CATONSVILLE, MD DEITRESS L. RUFFIN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/02/06 WINDSOR MILL, MD KING MEMORIAL PK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death e Cause (Final End-Stage Physician Liver dise or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hen Atiti Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or 3 a consequence of) Examiner burial-tran Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. \$ mmunideticiena Syndrome VICAC 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 No 1□ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 27, 2006 25205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto md GBINC 6701 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

			For State	State of Maryl		artment of rtificate or			ZUUb	38077
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	/Medic	al	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town,	, or Location of De	Wo Vember	27, 2000 4c. County of Dea	
	Examin	eı	4920 Lindsa	of Road		3a1-	Amore		Na	,
ľ	Funeral Director			8ex 7. Age (In.,	yrs. Jast birthday) Yrs.	Months Day			9. Bin	thplace (State or Foreign
	rland ow		Usual Residence of Decedent 10a. State 10b. County		. City, Town or L					10d. Inside City Limits
	he Mar	ector	Ma	1/A	BAITI					1 Pres 2 No
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 show ha Madical Examinar must be notified at	Funeral Director	4920 Lindso	ry Koad		10f. Zip Code	2122	9	USA Citizen of What Co	ountry?
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Maryland	should be nd Mental marked of	To Be	19a. Informant's Name/Relationship	Coles	10h Maili	an Addison /Chin	Louis			7-0-41
	1 and 2 shu Health and am 27 Is m ither traum		Melanie Gi	ate wood	1620	Nu H	al Ave	Rural Route Number, C		25640
Baltimore,	8 - 1 - 5		20a. Method of Disposition 1 Paurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Removal from State	b, Place of Dispo	osition (Name of matory or other p		Date 200	c. Location City or	Town, State
Saltir	permit. Pag Depertment Important: I eny injury o		21. Signature of Funeral Service Lice	1.	2	2. Name and Add		Baltimora,	MD 2121	77/
	40 E ₹ Ø		23a. Part1. Enter the disease, or cor	nplications that caused the c	death. Do not en	oseph H.	Brown Jr ying, such as cardi	. F. H. 2/40 ac or respiratory arrest	N.Fulto	Approximate
3	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	rato.	14	Freih	it		Interval Between Onset and Death
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Box	ath certi tending or use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	etal death 3	□Ectopic pregnan			23d. Date of del	ivery Day Year
o.	t the dea by the eached f	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□ Pregnant at time 9□ Unknown	of death 5	Other (specify)		- 111	Month	Day 75a.
ds, P	Attending Physician: The law requires that the death certificate be executed in death. If death. ector: After this certificate has been signed by the ettending physicien and continue the funeral director, page 2 should be detached for use as the burial-transit.	þ	Part II. Other significant conditions Part II. Offer Significant conditions	contributing to death but not	resulting in the	nderlying cause g	grven in Part I.			the cause of death?
Records,	aw requ Is been 2 shou⊦	Completed	Emplysa	13				24a. Was an	24b. Were au	itopsy findings available
	n: The licate har.							autopsy performed	d? death?	completion of cause of 2□ No
ž	ysiclar is certi directo	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	Hospital:	2 ☐ ER/Outpatie	nt 3 DOA)thor	Home 5 Residence		c(fv)
Division of Vital	ding Ph h. After th funeral	tlon:	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	r) 28b. Time o	W	ury at ork? Yes 2 \(\text{No} \)	28d. Describe how	injury occurred	
isix	r Attendi ter death. irector: A	Certification:	2 Accident investigation 3 Suicide 6 Could not 1 4 Homicide determined	be 200 Bloom of Injury	At home, farm, st			28f. Location (Stree City or Town, S	it and Number or Ru State)	ural Route Number,
Ω	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 1 Certifying P			h occurred at the	time, date and place			stated.
	To the Ho within 24 I To the Fu completely	Medical	(Check only one) 2 Medical Example one) 29b. Signature and title of certifier	hysician: To the best of my imper: On the basis of exam and manner stated.	nination and/or in					
1	T W I		255. Signature and title of pertitely	D1 682		and the same of th	nse number		Date signed (Monti	18 2006
	10		30. Name and addless of person who	60 GA	160 ch	Print)	Cole	unhos A	1) ZI	1044
	Sta Registr		31. Date filed (Month, Day, Year)	32. Sigistrar's Si	ignature	parle	741			,
982		2	NOV 3 0	LUUD Bellevil	20	-				

	1	For State Registrar		•	rtment of H tificate of L			g. No.	
Physicia	an	1. Decedent's Name (First, Middle, Last) Keith	s.	Rol	oinson		2. Date of Death Morth	Pay 6 Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give so Levindale N.H.	treet and number)			Location of Death		4c. County of Dea	th
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 6-1-1	Year) C	thplace (State or Foreign ountry) Md .
•how		Usual Residence of Decedent 10a. State 10b. County Md . NA	10c. City	y, Town or Loc					10d. Inside City Limits Yes 2 □ No
a or 28a-f	Funeral Director	10e. Street and Number 3800 W. Belvedere	Ave. Apt. 5	518	10f. Zip Code 21215		10	ng. Citizen of What C	ountry?
Department of Health and Mental Hygiene. Important: or items 23s or 28s-f show important: If item 27 to marked other than "natural; or items 23s or 28s-f show eny injury or other traumatic event, the Medical Examinating must be notified at 000s.	<u>ک</u>	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: B.	ite, etc.
ne. han "natura e Medical E	Completed	15. Decedent's Educ (Specify only highest grade		(Give	ent's Usual Occupa kind of work done of DO NOT use retired	during most of work	king	16b. Kind of Business	s/Industry
other t	Be Co	8th grade 17. Father's Name (First, Middle, Last)			abled		ne (First, Middle, A	Maiden Sumame)	ohngon
narked	To	Vernon 19a. Informant's Name/Relationship (Type	Robin		a Address (Street	Justi		. City or Town, State,	ohnson Zip Code)
alth and 27 le r		Elzine Robinson	Daughter	1742	N. Warw	ick Ave.	Baltimo	ore, Md.	21216
nent of He ant: If item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		sition (Name of natory or other place nt Cem.		1-06	20c. Location - City o	
Departr Imports eny inj gace.		21. Signature of Funeral Service Licenses 23. Part1. Enter the disease, or compli	wans	_		North Ave		H. East more, Md.	21202
nysician Medical Medical xaminer transit trans	dical Examiner	shock, or heart lailure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecut	juence of):					Onset and Death
e attending ad for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)	/		23d. Date ol d Month	elivery Day Year
De go	by	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	nderlying cause giv	ren in Part I.	23e. Did to		to the cause of death? Probably 4 Unkno
e has b	Completed						24a. Was a autops perform	sy prior to	
is certific director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 Yoo 27. Manner ol Death	Hospital: 1 hpatient 2 2	ER/Outpatier	IL SLI DOA	ner: 4 🗆 Nursing H		ence 6 Other (Spow injury occurred	pecify)
after death. I Director: After the in by the funeral	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year) 28e. Place of Injury - At h	Injury	M 1 □	rk? Yes 2 □ No	28f. Location (S City or Tow	treet and Number or	Rural Route Number,
ours afte naral Dir filled in		29a Certifier Certifying Phy	building, etc. (Speci sicien: To the best of my kn ner: On the basis of examin	owledge, deat	h occurred at the ti	me, date and place	a, and due to the c	ause(s) and manner	as stated. ue to the cause(s)
within 24 h To the Fur completely	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens			9d. Date signed (Mo	
\$ ₩ 8		ally Iller		-	- De	3767		11/23/0	amer ne
1		- 1.5 /	ompleted cause of death (Ite	m 23a) (Type,	Print)		72/10	11/2-1	1.

Robinson, Keith

State of Maryland / Department of Health and Mental Hygien 2006

For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 28, 2006 Month **Physician** Margaret Patricia Agnes Ruff 3:15 A M Nov. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Joseph Richey House Hospice Birthplece (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year **Funeral** 1 □ M 2 🗷 F Months Days Hours Yrs. 1935 219-30-7159 Sept Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ir then "neture!", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at Baltimore Maryland N/A 1 Tyes 2 No Direct 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 1315 Webster Street 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ [XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 A No Specify: Specify: White 21215-003 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife & Mother Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) 2 should be finance and Mental File marked of Dorothy Agnes O'Neill Edward Joseph Durkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health at Important: If Item 27 le any Injury or other treu Joseph E. Ruff (Husband) 1315 Webster St., Baltimore, Maryland 21230 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 12/1/06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune)al Service Licensee Kevin E Ecker 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A. 130 E. Fort Ave., Baltimore, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificete hes been signed by the ettending physicien and irrector, page 2 should be deteched for use as the burial-transit Due to (or as a consequence of): Physician/Medicai 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 € No o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Records. 3 Probably 4 Monknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No iere! Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Tother (Special Medicai Certification: To 1 ☐ Yes 2 1 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29b. Signature and title of certifle 32. Registrar's Signature 31. Date filed (Month. Da State Registrar

DHMH 17 Rev 1/2001

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WILSON aulette Diler 1.2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrd. last birthday) Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 ☐ F 60 212-44-0474 Yrs. Director 27,1946 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is man'ed other than "natural" or items 23a or 28a-1 show Injury or other traumati. event, the Medical Examiner must be notified at 1 Yes 2 No Director Md Raltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2430 Linder 21217 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 2No is mar' ed other than "natural" or Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black Baltimore, Maryland 21215-003 Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) TA Service nformation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ LUINET a 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Husband permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any Injury or other trau Linder Ave Baitimore EN NIS 30 Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation ameter, Dec 2, 2004 Randallstown 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Chatman-Harris Funeral Home 5240 neisterstown nd Baltimore enor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** eumoned Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 2□No P.0. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 2 No 3 Probably 4 Denknown 1 Tyes Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autonsy perforn Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Dres 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA ဥ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address person to the filed (Month, Day, Ye

on who completed cause of death (Item 23a) Type, Print

32. Registrar's Signature

			1 - For State Registrar	State of Maryla	nd / Depa	artment of tificate of	Health a	and M	ental Hy	giene 0	06	38081
			Hegistrar Decedent's Name (First, Middle, La	st)		inicate of	Death		2. Date of De	Reg. No.		3. Time of Death
	Physici		MARTHA SMITH	•					Month	29,2	Year	05:40 AM
	/Medic Examin		4a. Facility Name (If not institution, give	re street and number)		4b. City, Town,	or Location of		NUU.		nty of Death	03-40 11
ı	LXdtilli			GENTATRIE	CHOTER	BALTI	MORE	CIT	Y		N/A	
12	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs	s. last birthday)	If Under 1 Yea Months Day	r If Under		8. Date of Bir (Month, Da			place (State or Foreign
ь	Director		213-30-29/3	^{1□M 2} ▼ 68	Yrs.	WOTHITS Day	3 710013	191111.	06/30	1938		RYLAND
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation						10d. Inside City Limits
	Aaryli reho	ō	MD N/Z				т отп	137				1 TyYes 2 □ No
	28a-	rect	10e. Street and Number	2	DF	LTIMOR		Υ		10g. Citizen o	f What Cou	**
	3a or	0	4109 BOARMAN	AVENUE		1011 2117 0000	212	15		USA		,
	s within 72 hours after death with the Maryland liene. r than "natural", or items 23a or 28s-1 ehow the Macinal Examination indiffed at	Funeral Director	11. Marital Status	12. Was Decedent Ever in	U.S. 13. y	Was Decedent of f Yes, specify Cu			cify Yes or No		ace - Ameri	
9	or ite	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	1			i, Puerto i	Rican, etc.)		lack, White,	
21215-0036	ours iral',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1□Yes 2M∏N	o Specify:			Spec	nty: BI	LACK
5	72 h	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	tent's Usual Occ kind of work don	e during mos	t of workir	ng	16b. Kind of	Business/In	ndustry
12	within ene.	m D	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use reti	red)			DATM	TMODE	E CITY
d 2			10TH 17. Father's Name (First, Middle, Last)	BUS	AIDE	18. Mothe	er's Name	(First, Middle,			CITY
an	d la d	To Be	ERNEST CONNO									
Maryland	should nd Men marke umatic	-	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Stre			ROOMS I Route Number		m, State, Zi	p Code)
	s 1 and 2 should f Health and Men item 27 le marke other traumatic		CHERYL NELMS /	NIECE	3717	COLUM	BUS D	DTVE	PAT.	TIMODI	e Mr	21215
Je,	item item		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other p	iace)	D	ate	20c. Location	n · City or T	21215 own, State
Ē	Pages nent of ant: If it ary or o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		D VETE	RÁNS Ć N FORE	TM.	12/0	08/06	OWING	GS MI	LLS, MD
Baltimore,	permit. Pages 1 Department of H Importent: If its any injury or of once.		21. Signature of Funeral Service Lice	nsee	22	. Name and Add	ress of Facilit	y HC	OWELL	FUNERA	AL HC	ME 21207
_	20549		// /when	10 / au							BALTI	MORE, MD
			23a. Farther the disease, or consheck, or hear hailure. List only	plications that caused the one cause on each line.	ath. Do not ent	er the mode of d	ying, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease of condition resulting in death)	a. ACUTE	REN	AL	FAIL	UR	E			Offset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):							
		-	Sequentially list conditions,	b. SEPSIS Due to (or as a conse								
,	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		- 440							
Ţ,	be executed icien and burial-transit	Еха	that initiated events resulting in death) Last	C. Due to (or as a conse	equence of):							
760,	S S	cal	(d							}	
68	ntifica ng ph as th	Medi	IF COUNTY								The state of the s	
Вох	th cer tendir r use	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		Ectopic pregnar	ncv			1	Date of deliv	,
	e dea the et	Physician/Med	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at time of 9☐Unknown		Other (specify)					Month	Day Year
P.O.	The law requires that the death certifica tie has been signed by the ettending phoage 2 should be detached for use as the	P.	Part II. Other significant conditions	contributing to death but not r	aculting in the u	adashina anusa	nuen in David		220 Did t	obassa usa sa	natributa ta I	he cause of death?
ds,	w requires that s been signed t should be deta	d b	RESPIRATOR		_	ilderlying cabse (given in ranti.			Yes 2 No		bably 4 Unknown
Sor	v requ	ete	HYPERTEN									
Re	The law	Completed by	MYPERIEN	131070					24a. Was autor perfo	psy prmed?	prior to co death?	opsy findings available empletion of cause of
la		e C	25. Was case referred to medical				00 51	-4 D4b		2 No	1 🗆 Yes	2 No
>		OB	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	□ FB/Outpatier	t 3 DOA)thor		n <i>(Check only o</i> me 5□ Resi		ther (Speci	6(1
10	g Physical this	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of				28d. Describe			
Division of Vital Records,	Attending r death. ector: After by the fune	Certification:	1 XNatural 5 Pending 2 Accident investigation	n	injury		Yes 2	No				
ivis	or Atterdender Directo	tHo	3 ☐ Suicide 6 ☐ Could not to determined		home, farm, str	eet, factory, offic	е	2	28f. Location (- City or To	Street and Nui wn, State)	nber or Rur	al Route Number,
Ω	urs af	Cel	5.3									
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my k miner: On the basis of exami	nowledge, death nation and/or in	n occurred at the vestigation, in my	time, date an popinion, dea	id place, a th occurre	and due to the ed at the time,	cause(s) and date and place	manner as s e, and due !	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Lice	nse number			29d. Date sign	ned (Month	Day Year)
	F 3 F 8		N 1 1	1.40 0				27		_		
7	1		30. Name and address of person who	completed cause of death (It				V- 1		11/1	7/0	0
	6		CITANI WILL DE	HINAT 247	LL 12)	BEINE	DERE	Ai	IE, BA	HTIMI	RE.V	nn 21215
	Sta		31. Date filed (Month, Day, Year)		nature				7 1000 4			
36	Regist	ar .	NOV 2 0	2006	Ji A	ales .						
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Smith, Martha

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 38082 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 27, **Physician** 9:01 A M Margaret Ann Smith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Marlboro Prince George's 17215 Clairfield Lane If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 10, 1948 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours Mary I and 58 Director 216 50 9892 Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Upper Marlboro Maryland | Prince George's Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17215 Clairfield Lane 20772 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Senior Editor U.S. Census Bureau 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Louise Medley Aquilla Leo Hawkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17215 Clairfield Lane, Upper Marlboro, MD 20772 Neeland Queen (Companion) 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec 1, 2006 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 0015 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Metas Immediate Cause (Final **Physician** year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed the burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1∐ Yes 2 No i or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Medical 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arati Desai. MD 401 North Broadway, Suite 1400, Baltimore, MD 21231 32. egistrar's Signatur

State Registrar

	4	For State Registrar			ertificate of			Reg. No		3808	3
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygienes 38084 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2000 **Physician** 10:00 PM John Leopold Schneider /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Manchester Carroll 2636 Bert Fowler Road 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs last birthday) Social Security Number 6. Şex 1 M 2 ☐ F **Funeral** Days 218-01-9052 Months Hours Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28e-f show the Medicul Exactine must be notified at MD. Carroll Manchester 1 ☐Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 21102 2636 Bert Fowler Road U.S.A. 238 by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? ↓ Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify: Specify 3 □ Widowed 4 □ Divorced 'natural', Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 7 al Hygiene. College (1-4or 5+) Elementary Secondary (0-12) Meat and Wilk Inspector State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be innent of Health and Mental in item 27 is marked o James Alva Schneider Ella M. Nusbaum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2636 Bert Fowler Road Manchester. Md. Dara Webber - Friend other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Millers Church Cemetery Dec. 1,2006 Millers, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee He 3296 Charmil Drive Manchester, Md. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) succestiac /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner inding physicien and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Month Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has t irector, page 2 s autopsy performed? Yes 2000No 1 Yes or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funerel Direct completely filled in by 4 - Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State of Maryland / Department of Health and Mental Hygiene 38086 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2006 **Physician** 9:45 p. M Nov. MARGARET DILL SWOPE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Blakehurst Health Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 14, 1911 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1□M 2√2F 212-52-5936 95 Yrs. Mary Land Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 🏋 No Director Maryland Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 U.S.A. 1055 Joppa Road Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify. ģ 3√Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be tiled v Department of Health and Mental Hygier Important: if Item 27 is marked other tt any injury or other traumatic event, IIIa once. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Margaret Chambers E. Allan Dill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4400 Atwick Road Baltimore, Maryland 21210 Margaret Gans (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State netery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Green Mount Crematory 11/30/06 Paltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld F.H. 21. Signatur of Fune al Service Liter 6500 York Road Baltimore, Maryland 21212 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic **Physician** 66 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Life, underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires thet the death certificate be executed burial-transit ete hes been signed by the ettending physicien and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed/ this certificete 1 Tes 2 🗹 No after death.

Director: After this certific
Jin by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Certification: To 27. Mancer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and Itle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . McConnell illian D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

		1	For State Registrar	State of	f Maryland		rtment of tificate of		Mental Hygi	ene 2006	38087
	Physicia	_	1. Decedent's Name (First, Middle	Last) TAYLDA	2				2. Date of Death Month	Day Year 28 200	
j.	/Medic Examin		4a. Facility Name (If not institution,	give street and num			0	or Location of Dea	ath	4c. County of De BALTIM	ath
	Funeral Director				7. Age (In yrs. la	ast birthday). Yrs.	If Under 1 Yea Months Day	r If Under 24 Hi			irthplace (State or Foreign Country)
	aryland show		Usual Residence of Decedent 10a. State 10b. County Md.	NA	10c. City	, Town or Lo	cation Ltimore				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the M a or 28a-f be notifie	Director	10e. Street and Number 2820 Winwood				10f. Zip Code	.225	10	g. Citizen of What C	21
9	within 72 hours after death with the Maryland ene. Than "natural", or Iteme 23a or 28a-f show In Medical Examinar must be notified at	Funerai	11. Marital Status 1 Never Married 2 Marri	12. Was Dece Armed Fo ed 1 □Yes	2 No	l l	Vas Decedent of	Hispanic Origin? Joan, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - An Black, Wh	ite, etc.
21215-0036	"natural", o	leted by	3 V Widowed 4 □ Divorced 15. Decedent (Specify only highes		ates:	16a. Deced	lent's Usual Occ	upation e during most of w	rorking	Specify:	Black s/Industry
N	filed withir Hygiene. other than	e Completed	Elementary/Secondary (0-12) 11th grade 17. Father's Name (First, Middle, and a secondary (0-12)	College (1	-4or 5+)		abled	,	ame (First, Middle, M	NA faiden Sumame)	
Maryland	2 should be f and Mental P is marked of reumatic eve	To Be	Thomas 19a. Informant's Name/Relations!	nip (Type, Print)	Howar		g Address (Stre	Rita et and Number or	Aural Route Number,	Parke	
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Iteme 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at Once.		Faye Tiffany To 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S)	3 □Removal from	State	ace of Dispo	sition (Name of natory or other p	lace)	le, Baltin Date 2 -04-06	nore, Md. 20c. Location - City of Crownsvil	
Balti	permit. Depertm Imports eny inju		21. Signature of Funeral Service	e offen				North Av	March F. e., Baltin	nore, Md.	21202
7 ,0928	Physician // Medical Examiner and physician and physician and the priting it. It ansit the priting it.	ical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	(or as a consequ	DIOM Suence of): USPID	SHOCK 10 PATH			st,	Approximate Interval Between Onset and Death DAYS WEEKS
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Ö	To the Hospitel or Atland within 24 hours etter death To the Funerel Director: / completely filled in by the fi	dicai Cer	29a. Certifier 1 A Certifyir	g Physician: To the	best of my kno	wledge, deat			ace, and due to the co	ause(s) and manner	
)	To the Mithin 24 To the F	Medi	29b. Signature and title of certifie	and man	ner stated.		29c. Lice	onse number 0 6 48/	4	9d. Date signed (Mo	nth, Day, Year)
	2		30. Name and address of person	who completed cause	se of death (Item	23a) (Type,	Print)	ME	6-AZF, 11	INF 1	10 21208
lar.	St Regist	ate rar	31. Date filed (Month, Day, Year) NOV 3 0	2006	Registrar's Signa	ture	alles				10 21208

			For	State o	f Marylan	d / Depa	artment of	of Health a	and Mental	Hygiene	3	
		1	State Registrar			Cei	tificate	of Death		Reg. No	2006	38088
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Fun	oral			Larl TI	7. Age (In yrs.	last birthday)	If Under 1		24 Hrs. 8. Date	of Birth	9. Bit	thplace (State or Foreign
Direc			216-28-5170	1 □ M 2 /2 /F	77	Yrs.	Months D	Days Hours	Min. Oct.	of Birth h, Day, Year 9,192	9 Mar	yland
pug *	ea Y	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
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г деат	S I	ner	11. Marital Status	Armed Fo		.S. 13.	Was Deceden	nt of Hispanic Ori Cuban, Mexicar	igin? (Specify Yes n, Puerto Rican, et	or No- c.)	14. Race - Am Black, Whi	
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ING XIXID-UUSO be filed within 72 hours after death with the Marylan ital Hygiene. Indicate then "naturel", or itema 23a or 28e-f ehow	CH E	ed	15. Decedent's	Education	4103.	16a. Dece	dent's Usual (Occupation		16b. h	(ind of Business	
7 Pin 12	Medi	Completed	(Specify only highest s Elementary/Secondary (0-12)	grade com <i>pleted)</i> College (1	1-4or 5+)	(Give	bind of work of DO NOT use	done during mos retired)	it of working			
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iand Id be file ental Hy ked oth	eve.	Be	17. Father's Name (First, Middle, La Charles Harvey Ta						er's Name <i>(First, M</i> a Belle P		n Sumame)	
should by marked	matic	၉	19a. Informant's Name/Relationship		-	19b. Mailir	na Address (S		er or Rural Route I		or Town, State,	Zip Code)
Man nd 2 sl lith an 27 ior	other traumatic	1	Angela Leitzer (1						Notting			1
		1	20a. Method of Disposition			Place of Dispo cometery, crei	sition (Name matory or othe	of er place)	Date	20c. L	ocation - City o	r Town, State
Pages ment of tent: if it	ury or		XX Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		HO							Maryland
Daitimor permit. Pages Depertment of important: if it	any injury once.	1	21 Signature of Fune al Constitution	ensee)	22	2. Name and	Address of Eacili Bruzdzi	nski Fun	eral H	ome, P.	A.
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Physic /Med			disease or condition resulting in death)	a. Sugaro	OCIUM (or as a consec		1ema	toma				
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58/ ifficate g phys	s the			d					\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\			
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90	al direc	To B	examiner? 1 ☑ Yes 2 ☐ No			ER/Outpatie	nt 3 DOA	Other: 4 N	ursing Home 5□			ecify)
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DIVISION To the Hospital or Attendit within 24 hours effer death. To the Funeral Director: At	y fille		29a. Certifier 1 Certifying (Check only 2 Medical C	Physician: To the	e best of my kn	owledge, deal	th occurred at	the time, date a	nd place, and due ath occurred at the	to the cause(s) and manner a	as stated.
To the H within 24 To the F	plete	Medical	one)		nner stated.	ation and/or n			attroccorred at the			
o t	CO	2	29b. Signature and title of certifier		A		290.	License number		290. 0	ate signed (Mgr	Min, Day, Year)
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2			Dr. William S		usky		-	wklin S	QUALEDI	2. 21	237	
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Re	egistı	ar	NOV 3 0	2006	ر مدورون	B. A.	20025					

			1 - For State Registrar		State of Ma	arylan		artment rtificate				lental Hy	/giene,	11116	-	38089
Н	Physici	an	Decedent's Name (First, Mid	dle, Last)			·π	atum	.Tr			2. Date of D Month	eath Day 23	Yea	500	3. Time of Death
	/Medic Examir	cal	Jesse 4a. Facility Name (If not institut Genesis Eld				.	4b. City, T	own, or			11	4c. (County of De	ath	
	Funeral Director		5. Social Security Number 294-22-8880	6. Sex	7. Age	76	last birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	ay, Year)	O 9. E	Sirthpla Country	ce (State or Foreigr y) OH
	land		Usual Residence of Decedent 10a. State 10b. Cour	ty		10c. City	y, Town or Lo	ocation							100	Inside City Limits
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215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 23 is marked other than "natural", or itema 23s or 28s-f ahow other traumatic avant, the Medical Evarinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married M M 3 Widowed 4 Divorce	rried	12. Was Decedent I Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:			was Decede If Yes, specif 1 ☐ Yes 2/2				ecify Yes or N Rican, etc.)		4. Race - Ar Black, W Specify:	hite, et	c.
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<u>lan</u>	Aental Aental rked tic av	To B	Jesse Tatum	Sr.					F	ran	ces	Wilke	rson			
Maryland	2 sho and h is ma	. 0	19a. Informant's Name/Relatio		•											ode) 21117
	1 and 1ealth em 27 ther tr		Bonnie Tatum 20a. Method of Disposition	-Wi	te ————	20h P	and the second s					APT L		ation - City		lls, Md
Baltimore	t. Page rtment c rtant: if njury or		1∑ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other 21. Signature of Fuperal Service	(Specify)				n For	est	. Ve	t 12			-		ls, Md
Ba	Dep Impo		21. Signature of Puberal Service	The second	K. In	han) 4	arch 300 V	TYT Vaba	∄″We ash	št Ave,	Balt	imor	e, Mo	É	21215
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, shock, or hear failure. L Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	st only or	Due to (or as:	N AR a consequ 4 O ^ a consequ	uence of): J I A uence of):	RIER	.4	DIS	EAS	E		4	C	opproximate niterval Between onset and Death
8760,	icate be executed physicien and s the burial-transit	cal	that initiated events resulting in death) Last		Due to (or as			ع دري	<u>(_ {</u>	<i>1</i> C	15-0		ero		OT.	ugs
P.O. Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rall director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal	death 3	Ectopic pre					2	3d. Date of o		ay Year
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Vital	ician: ertific ector,	Be	25. Was case referred to medi- examiner?	-	annital:				04-		of Death	(Check only	one)			
of	Phys this ral dir	.T	1 Yes 2 No		ospital: 1 ☐ Inpatie 28a. Date of Injur	_	ER/Outpatier 28b. Time of			4 NI		me 5 Res 28d. Describe			oecify)	
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	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (29a. Certifier 1 Certific (Check only one)	ring Phys of Examir	sician: To the best of ner: On the basis of and manner sta	examinat	wledge, deatl tion and/or in	h occurred at vestigation, i	t the tim	e, date ar inion, dea	nd place, a	and due to the	cause(s) a , date and p	and manner place, and d	as stat ue to th	ed. ne cause(s)
	Vith To t	Σ	29b. Signature and title of certi	ier						number			29d. Date	signed (Mo	nth, Da	y, Year)
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	6		30. Name and address of person Shallon Month, Day, Yea	ale	mpleted cause of de Spta 32. Registra	965	0 50	antic	ngo	Re	00	, su	te 1	200	Co1	unbic 45-
	Sta Registi		or. Date filed (Moliffi, Day, 198	"/	32. Medistra	a s signa	B. A	and B								
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			1 - For State of Ma	ryland / Depa <i>Cei</i>	artment of Hortificate of L			ene 006	38090
	Physici		1. Decedent's Name (First, Middle, Last) Alice B.		Thomas		2. Date of Death Month	Day Year	1/2 0 3 1/14
*	/Medio Examir		4a. Fecility Name (If not institution, give street and number) GOOD SAMAR(7ANS HDSP)	7 A	4b. City, Town, or BALTI		NOVEMBE	4c. County of De	9
¥	Funeral Director			(In yrs. last birthday) 80 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3-14-)	rear) (rthplace (State or Foreign country)
	ryland thow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	the Ma	Director	Md. NA	Balti	more		10	g. Citizen of What C	Yes 2 No
	23a or	rai Di	3018 Mayfield Ave.		21213			USA	, and the second
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Itema 23e or 28e-f ehow aumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes, 2 X No Year or Dates:	o	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecrfy Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: B]	ite, etc.
21215-0036	within 72 hound.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Give life. I	dent's Usual Occupa kind of work done do DO NOT use retired)	urina most of work	ang	6b. Kind of Business	,
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Maryland	hould b d Ments marked matic e	To	Anderson 19a. Informant's Name/Relationship (Type, Print)	Beach	an Address (Street a	Mary	al Route Number	Johnson City or Town, State,	
	ges 1 and 2 should it of Health and Men if Item 27 is marke or other traumatic		Chantae A. Rogers Daug		Mayfield				
Baltimore,	Pages 1 ment of He ant: If Iten ury or oth		20a. Method of Disposition 1	20b. Place of Dispo cemetery, cren King Men	natory or other place	12–1		oc. Location - City of Randallsto	
Balt	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service Licensee	-0-	Name and Address	orth Ave		more, Md.	21202
	Physician		23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition).					Approximate Interval Between Onset and Death
	/Medical Examiner			consequence of):				3)((L()))	<u>.</u>
/	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):		7/22/18	/V		
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ō	ng Ph Iter th Ineral	ation: To	1 Yes 2 No nospital: 1 Impatien 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28b. Time of	28c. Injury	4 Nursing Ho	me 5 Resident	ce 6 Other (Sperinjury occurred	ecify)
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injurbuilding, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	ne Hospit n 24 hours ne Funera	edicai (29a. Certifier 1 Certifying Physician: To the best of (check only one) 2 Medical Examiner: On the basis of and manner state	examination and/or inv	occurred at the time restigation, in my opi	e, date and place, nion, death occurr	and due to the cau red at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To t Withi To tl	M	29b. Signature and title of certifier Artical	DINY	29c. License		290	d. Date signed (Mont	th, Day, Year)
	2		30. Name and address of pers in who completed cause of dea	ath (Item 23a) (Type,	Print) GOOD	SAMARI	7AN 1	Hosp 17m	43 0006
1	Sta		31 Date filed (Month Day Year) 32° Registrar	's Signature	e , M	(1)			
1	Registr	ar	NOV 3 0 2006	St. Spa	Che I				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #19a Per FH G862 12/15/06 JH. Certificate of Death Red. No. 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1.30 **Physician** Thornton Paulette 01/embel 28,2006 aM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Paryland Greneral Baltimore NA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2√ F 46 218-74-4833 Md. Director 1-2-1960 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c, City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 Yes 2 □ No Funeral Director Md. NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21218 820 Argronne Dr. Apt. J 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 TYes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify. Be Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NA Student 2 yrs. 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hollie Bernice Thornton ၉ Lee James 19a. Informant's Name/Relationship (Type. Print) Royster Brenda C. Thornton ... 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2833 Woodbrook Rd., Baltimore, Md. Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Randallstown, Md. King Mem. Park 12-2-06 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East 21202 1101 E. North Avenue, Baltimore, Md. an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HOBULRED Physician /Medical Que to (or as a consequence of) **Examiner** umoria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Arter this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, δ 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 D No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of he who completed cause of death (Item 23a) (Typg, Print) aryland Guneral 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

	•	For State Registrar	State of	of Mar		partmei e <i>rtifica</i>			Mental Hyg	ene2006	38092
		Decedent's Name (First, Middle, Last)						2. Date of Deat	-	3. Time of Death
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/Medic	al	*			- T T D		. Tau-	Location of Dogs		20, 2006 4c. County of Death	
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Funeral		5. Social Security Number 6. Se	x]M 2□F		In yrs. last birthda 1 Yrs.	Months		Hours Min.	(Month, Day,		nplace (State or Foreign untry)
Director	}	217-32-2517 X		7.	L				June 16	5.1935 Mar	yland
and *	1	10a. State 10b. County		1	Oc. City, Town or	Location					10d. Inside City Limits
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		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that ne cause on	caused the	ne death. Do not	enter the mo	ode of dyin	ig, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
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sicia cert irect	o B	examiner?	Hospital:	Inpatient	2 ☐ ER/Outpa	tient 3 🗆 [Oth	05	Home 5 Reside		ofte)
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After Property	흔	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		nth, Day	Yea <i>r)</i> Inju	y M		k? Yes 2⊡No			
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ppita ours nerai		29a. Certifier 1 Certifying Phy	vsician: To th	ne best of	ny knowledge, d	eath occurre	ed at the tir	me, date and place	e, and due to the ca	ause(s) and manner as	stated.
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			For State Registrar	Otate of Maryla		tificate of		, ,	g. No2 0 0 6	38093
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1	/Medic Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Death	Novembe	4c. County of Dea	
			Future Care Nurs 5. Social Security Number 6. S		rs. last birthday)	Clinton If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	Prince G	eorge's
	Funeral Director			□M XXF 76	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct 31,	1930 Nor	ountry) Carolina
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	ne Mar 8a-f sl ptiffied	ector	Maryland Prince C	eorge's	Temp	le Hills				1 □ Yes 2 No
	th with the 23a or 2 ust be no	Funeral Director	10e. Street and Number 5009 Thuman Dri	.ve		10f. Zip Code	20748	10	g. Citizen of What C United	
960	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or Items 23a or 28a-f show event, the Medical Exyminer must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ 100 If Yes, Give 111 Year or Dates:		Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 XX No	lispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
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and	0 = 0 5	To Be	17. Father's Name (First, Middle, Last, Joseph Morton	•			18. Mother's Name Bessi	(First, Middle, Mi	· · · · · · · · · · · · · · · · · · ·	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be to Department of Health and Mental Important: If Item 27 is marked or any injury or other traumatic evenore.	ř	19a Informant's Name/Relationship (Merrell B. Talle	City or Town, State,						
ore,	jes 1 au of Hea if Item or othe		20a. Method of Disposition 1 □ Burial 2 🕅 Cremation 3 □	20b	. Place of Dispos cemetery, crem	sition (Name of natory or other plac	_{ce)} Nov 23 ^D	ate2006 20	Oc. Location - City or	Town, State
Ē	it. Pag intment intant: injury o		4 □ Donation 5 □ Other (Specif. 21. Signature of Funeral Service Licer	Clinton. M	iD					
Ba	perm Depa Impo any t		21. Signature of Political Service of Cer	Poulpo	0.5 A1	exandria	^{ss of Facility} Lee Ferry Roa	Funeral d. Clint	. Home,Inc	6633 01d 0735
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de one cause on each line.						Approximate
	Physician /Medical	ľ	Immediate Cause (Final disease or condition resulting in death)	a. CARDIO		RY FAILUR	E			Onset and Death YEARS
	Examiner	١.,	Conjuntially list conditions			RY DISEAS	E			YEARS
	ted sit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons		UZTMED! -	DICEACE			YEARS
o,	icate be executed physician and s the burial-transit		that initiated events resulting in death) Last	cDue to (or as a cons		IEIMER's	DISEASE			TEARS
68760,	cate be physici the bu	Medical		d						
.O. Box 6	death certif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3 🗆	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
<u> </u>	quires that the de n signed by the a lld be detached f	by	Part II. Other significant conditions of	ontributing to death but not r	esulting in the un	derlying cause giv	en in Part I.	23e. Did toba		o the cause of death?
Records,	sician: The law requires that the certificate has been signed by the rector, page 2 should be detache	Completed						24a. Was an autopsy performe 1 Yes 2	prior to death?	utopsy findings available completion of cause of
Vital	sician: certifica rector, p	Be C	25. Was case referred to medical examiner?	Hospital		low	26. Place of Death			<u> </u>
0	Phys er this eral dir	: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	1 3 DOA Oth 28c. Injur Wor	41- I Nursing Hom	ne 5 Residen 8d. Describe how	ce 6 □Other (Spe	ecify)
Sion	tending leath. tor: After the funer	ation	1 ♠ Natural 5 Pending 2 Accident investigation		Injury		k? Yes 2□No			
Division	ter d Irec	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spe	home, farm, stre cify)	eet, factory, office	2	8f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	ledical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the tir	me, date and place, a pinion, death occurre	nd due to the cau ed at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	2		29c. Licens			d. Date signed (Mon	
	Y		• • • • • • • • • •	Y	00-1 /T -		51520		11-22-	0 6
	10		30. Name and address of person who Bahram Pishdad,	MD 1328 Sout	hern Av		ite 310, W	ashingto	n, DC 200	32
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	parki				

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reem Taylor			land / Department o		ental Hygiene	000	6 0000		
		1- For State Registrar	Certificate o	of Death		Reg. No. 200	6 3809		
Physicia edical Exami		1. Decedent's Name (First, Middle, Last) Tereem	Taylor		2. Date of E Month Novemi	Day Year Der 21, 2006	3. Time of Death 1842 hrs		
1		4a. Facility Name (if not institution, give street and University Hospital	number)	4b. City, Town, or Location Baltimore	on of Death	4c. County of Dea	ath ~?		
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		nder 24Hrs. 8. Date of	Birth(MM/DD/YYYY) 9. I	Birthplace (State or eign / Country)		
		213-11-1556 1 M 2 F Usual Residence of Decedent	2 Yr	s.	1 Aug	4, 1483	77 (100		
d now any		10a. State 10b. County	10c. City, Town or Loca		•		10d. Inside City Limits 1 Yes 2 No		
death with the Maryland or items 23a or 28a-f show must be notified at once.	ctol	10e. Street and Number	Baltima	10f. Zip Code		10g. Citizen of What Co	ountry?		
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with the ms 23a be noti	ırai	11. Marital Status 12. Was D		as Decedent of Hispanic			erican Indian, Black,		
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2 hours afte "natural", I Examiner	eted			nost of working life. DO N		160. Kind of Busines	s/industry		
5-0036 led within 72 hours after Hygiene. other than "natural", the Mr. is a Examiner	Completed	10		abover		Wareh	ouse		
215-0036 be filed within 7 ntal Hygiene. rked other thar ent, the Me is	Be Col	17. Father's Name (First, Middle, Last)	rr	18.Mot	her's Name (First, Middl				
Me Me	To B	1 a. Informant's Name/Relationship (Type, Print)		ng Address (Street and N	Number or Rural Route	Vumber, Lov Number, Lity or Town, Sta	ite, Zip Code)		
MD nd 2 sho alth and m 27 is aumati		Janice laylor	533	5 Winste	on Ane.	Bulto. Ud	. 21212		
ore, N. s. l. and of Health If item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal	from State 20b. Place of Dispo	sition (Name of cemetery, other place)	Date	20c. Location - City	or Town, State		
Page Page nent o		4 Donation 5 Other Specify:	Greenm	ount Cremate	m Dec 1, 20	of Balto. 1	id.		
Baltimore, permit Pages I a Department of He Important: If ite		21 Signature of Funeral Service Licensee	2	Name and Address of Do	ouglass Ful	neral Servi	ce P.A.		
Physician	-	23a. Part I. Enter the disease, or complications that	caused the death. Do not enter	70) McCullo	s cardiac or respiratory	arrest, shock, or heart	Approximate Interval		
/Medical		failure. List only one cause on each line.	Sunshot Wounds	, 5			Between Onset and Death		
Examiner			a consequence of):			ν.			
. /	<u>_</u>	Sequentially list conditions, b.	a consequence of);						
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ed nsit	Exal	events resulting in death) Last Due to (or as	a consequence of);						
an and all - trans	cal	UNPENDED . AMENDE)				To the second		
60, ate be hysicia e buria	Medi		s, outcome of pregnancy			23d. Date of delive	erv		
ox 68760, eath certificate be executed attending physician and for use as the burial - transi	an/l	23b. Was decedent pregnant in the	birth 2 F	etal death 3 Ect	opic pregnancy	Month	Day Year		
	Physician/Med	1 Vos 3 No 9 Unknown	gnant at time of death 5 0	Other (Specify)		1010			
ords, P.O. B. w requires that the de s been signed by the			to death but not resulting in the	underlying cause given in	Part I. 23e. Di	d tobacco use contribute	o the cause of death?		
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of Vital Records, ng Physician: The law requir the certificate has been someral director, page 2 should	Completed				24a. W au		autopsy findings available completion of cause of		
tal Records cian: The law requi certificate has been ector, page 2 should	omp	4	-		pe	erformed? death?			
	Be C	25. Was case referred to medical			ath (Check only one)				
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n of ading P th. : After e funers	Certification:	27. Manner of Death 1 Natural 5 Pending 28a. Da (Mor	te of Injury th, Day Year) 1, 2006 28b. Time of 1819 hrs	Injury 28c. Injury at W	Subject s	be how injury occurred hot			
Division tal or Attendii rs after death. al Director: A	icat	2 Accident Investigation 28e. Pla	ace of Injury - At home, farm, stre		, etc. 28f. Locatio	n (Street and Number or I			
ital or ral Div	ertii	- Galcide) Local Street		or Town 1700 block	n, State) W. Saratoga St., Balti	more, MD		
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the b	est of my knowledge, death occu			1 /			
To the within To the comp	Medical	2 Medical Examiner: On the basi and manner 29b. Signature and title of certifier		29c, License numb		29d. Date signed (A			
	=	70/-1110R	Q ,	O.C.M.E.		November 22,			
		30. Name and address of person who completed ca	use of death (Item 23a)						
2		Zabiullah Ali, M.D. Assistant Med		nn Street, Baltimore	e, MD 21201				
S	ate	31. Date filed (Month, Day, Year) /32.	Registrar's Signature						

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** NOVEMBER 23, М 2006 JOHN. TAN 1732 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F Director 015-50-2175 58 11/20/1948 SINGAPORE Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturai", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 TYes 2 No Directo MARYLAND MONTGOMERY NORTH POTOMAC 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 14620 ANTIGONE DRIVE 20878 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify Specify. þ 3 Widowed 4 Divorced ASTAN Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ CONSULTANT INFORMATION TECHNOLOGY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PAUL THIANG JIANG TAN SWEE YONG NG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14620 ANTIGONE DRIVE, NORTH POTOMAC, MEI TAN/WIFE MARYLAND 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN CEMETERY 12/02/2006 SILVER SPRING, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, in complications that cause one death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): minutes /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitai or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown been signed by should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 WUnknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? res 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₽No 2 ER/Outpatient 1 🔲 Inpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the within 7 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 23 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIT KALARIA, M.D., 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND 20850

State Registrar 31. Date filed (Month, Day, Year) NOV 3 0 2006

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

2. Registrar's Signature

06-09040 Edward Williams

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene 2006 38096

		1- For State Registrar	Certifi	icate of Death		Re	g No.	
Physicia ledical Examii	ın/	1. Decedent's Name (First, Middle, Last)	>h William	S		2. Date of Death Month November	Day Year	3 Time of Death 0624 hrs
		4a Facility Name (if not institution, give stre Sinai Hospital			n, or Location of D)eath	4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 220-92-3235 1 M	7. Age (In yrs. last b	oirthday) If Under 1 Months Yrs.	Year If Under 2 Days Hours	4Hrs. 8. Date of Birtl Min.	h(MM/DD/YYYY) 9 Birtl Foreign Cou	
Limore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene raut: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a State 10b County 10e. Street and Number 30 26 0 0 1 For 3 11 Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Years 15. Decedent's Education (Specify only him.)	Was Decedent Ever in U.S. Armed Forces? Yes 2 No is, Give Year Bates: ghest grade completed) College (1-4 or 5+) Ans William Print) Ans William 20b. Plac crem	13. Was Decedent If Yes, specify Control of Working Modern Control of Working Mailing Address (3026 On the of Disposition (Name natory or other place)	Definition of the second of th	d of work done e retired) Name (First, Middle, More ror Rural Route Number 1988)	14. Race - Americ White, etc. Specify: Blo 16b. Kind of Business/Ir Cateria Surname) Nes Der, City or Town, State, 20c. Location - City or	Indian, Black, Indian, Black,
Physician Peartm (Inhoraculary of Medical Examiner		23a Part I Enter the Isease, or complicat failure List only one cause on each li	ons that caused the death. Do	15245 R	usters to dying, such as card	own nd	Baltimore	Approximate Interval Between Onset and Death
	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	to (or as a consequence of)		_			
cuted and transit	ш	(Disease or injury that initiated C.	to (or as a consequence of):					
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OX 68 eath certifi attending for use as t	sician/M		Pregnant at time of death	2 Fetal death		regnancy	23d Date of delivery Month D	ay Y ear
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Division of Vital Records, tal or Attending Physician: The law require is after death al Director: After this certificate has been siled in by the funeral director, page 2 should be	ompleted		1			24a. Was a autops perfori 1 V Yes 2	sy prior to comed? death?	opsy findings available ompletion of cause of
Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to medical examiner?	tal.	26.	Place of Death (Cl	heck only one)		
f Vit Physic or this o	ToE	1 ✓ Yes 2 No	IIIpatient 2 LK	R/Outpatient 3 DOA	Other ₄ No. Injury at Work?		Residence 6 Other	
on of or or or or or or or or or or or or or	ion:	1 Natural 5 Banding	(Month, Day, Year)	, ,	Yes 2 X N		low injury occurred	
Divisior Spital or Attent hours after death meral Director: y filled in by the	ertification:	2 Accident Investigation 3 Suicide 6 X Could not be determined	28e. Place of Injury - At home	8:45 am a, farm, street, factory, of residence	ffice building, etc		treet and Number or Ruitate) 3026 Oakfo	ral Route Number, City rd Avenue
Divi To the Hospital or within 24 hours afte To the Funeral Dir	Medical C	29a Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: On	To the best of my knowledge, the basis of examination and/o	death occurred at the tir	me, date and place pinion, death occui	, and due to the cause	e(s) and manner as start	ed cause(s)
T ₀	Me	29b. Signature and title of certifier	d manner stated		o.C.M.E.		29d. Date signed (Mor	
		30. Name and address of person who com Susan Hogan MD. Assista	ple d cause of death (Item 23a Medical Examiner	a)		D 21201		
Si Regis	tate	31. Date filed (Mon) (Day Year) 200	Table 1					

State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month WILSONJR NovemBER 27,2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner SINAI HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 228-36-546 Usual Residence of Decedent 1 M 2 ☐ F Yrs. Director VIRGINIA 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits in than "natural", or items 23a or 28a-f ehow the Madical Examinar must be notified at 1X Yes 2 No Funeral Director MARYLAND 10e. Street and Number Citizen of What Country? 370 TON USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No þ Specify Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LEADENHALL BAPT. CHURCH YEARS 7 is marked other treumatic event, I 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event 9008. 18. Mother's Name (First, Middle, Maiden Sumame) Be WILSON ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Date 200 Location City 3703 EDGERTON RD. BERTHA G. WILSON (WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) BUTUS (EMETERY 12 22. Name and Address of Facility BROWN JR. FUNERAL JOSEPH CONTROL AVE., BALTINORE 21. Signature of Funeral Service Licensee FULTON AVE., BALTIMORE MO21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician ACUTE MYOCAKOIAL INPARCITION 30 MM /Medical Examiner ATHEROSCEROTIC HEARI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760. attending physicien for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by cate has been signification can be categorial care categorial cate 1 Yes 3 Probably 4 Unknown 24a. Was an autopsy performed?
1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital : After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation s after de. Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number ited cause of death (Item 23a) (Type, Print) WILLIAM JAQUIS, MO SINGAT HOSPITAL OF BALTIMORE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend item#16b State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 38098 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year 4:47 A M Wilson Jr. NOvember 26 John Daniel 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days 217-40-9468 1 X M 2 □ F 63 19 43 80 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Y Yes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 U.S.A. 2305 Lauretta Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Black Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Transportation Elementary/Secondary (0-12) College (1-4or 5+) Driver Transporation Service llth grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Perkins Scales John D. Wilson Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6115 Buckler Road, Clinton, Md 20735 Madeline Williams-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc 12/4/06 4 □ Donation 5 □ Other (Specify) Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West Ume shom pain 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulminary embolus one day Due to (or as a consequence of): cancer one year Sequentially list conditions, if any learning Learning Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

\$

Completed

Be

Funeral

Director

show r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be i

I Hygiene.

Department of Health and Mental Hygis Important: If item 27 Is marked other i any Injury or other traumatic event, <u>tt</u>

death

Pages 1 and 2 should be filed within 72 hours after

3altimore, Maryland 21215-0036

Examine burial-tran physician a Physician/Medical attending p ed by the þ Completed page 2 s certificate director. Be After

The law requires that the death certificate be executed

the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Certification: To after death in 24 hours the Funeral Dire Medical To the Hos within 24 ho To the Fun completely 1

Registrar

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No autonsy performe 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD

29c. License number D47123 29d. Date signed (Month, Day, Year) November 26 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

Juseph Puthumana 31. Date filed (Month, Day, Year)

NOV 3 0

inchen maina

29b. Signature and title of certifier

egistrar's Signature

memorial Hospital Baltimure Manyland

union

State

		1	- State Amend item#5,	State of Ma G861, 11/30/	arylan 06 TT		rtment of H		nd Mental Hy	giene Beg. No. 006	38099
	Physici	an	1. Decedent's Name (First, Middle, L.	Woo:	-1				2. Date of De Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)	270	DON.	4b. City, Town, or	Location of C	Death 9 12 11	4c. County of De	ath /
	Funeral Director		10,000	OMEUDOX Sex 1 M 2 DF	e (In yrs.	A JES 07 last birthday) 3 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir Min. (Month, Da	th 9.8	inthplace (State or Foreign Country) N.C.
	yland sow	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation				10d. Inside City Limits
	the Mar 28a-f sh	ector	Md.	NA		Bal	timore			10g. Citizen of What C	1 A Yes 2 No
	death with the Maryland ms 23a or 28a-f show rroust be notified at	Funeral Director	811 E. 34th St	,			2121			USA	
920	be filed within 72 hours after death with the Marylan Ital Hygiene. Id othar than "natural", or Rems 23a or 28a-1 show event, the Medical Evacities mast be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 22 If Yes, Give Year or Dates:	'	1	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin n, Mexican, F Specify:	n? (Specify Yes or No Puerto Rican, etc.)		
Maryland 21215-0036	in 72 ho n "natur Aedical	Completed	15. Decedent's I (Specify only highest g	rade completed)	E.\	16a. Deced (Give life. L	ent's Usual Occupa kind of work done of OO NOT use retired	ation during most o	f working	16b. Kind of Busines	Dept.
1212	e filed within al Hygiene. I othar than ' vent, tre Me		7th grade 17. Father's Name (First, Middle, Las	College (1-4or	o+)	Custo	dian-Supe		S Name (First, Middle		City Police
yland	2 should be f n and Mental h r is marked of raumatic eve	To Be	Will		Bryde			Fra	ankie	Smith	
	유 를 를		19a. Informant's Name/Relationship Beverly Ann Corn		nter				or Rural Route Numb t, Baltimo	er, City or Town, State, re, Md.	Zip Code) 2 121 8
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or othar trat		20a. Method of Disposition 1 Burial 2	☐Removal from State	0	emetery, cren	sition (Name of patory or other place Forest Ve		Date 2-6-06	20c. Location - City of Owings Mi	
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Lice	ensee Wa	na-		Name and Addres		March E ve., Balti	F.H. East more, Md.	21202
	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	nplications that cause y one cause on each li a	ine.		er the mode of dyin	g, such as ca	ardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
8760,	cate be executed physician and sthe burial-transit	dicai Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <u>Uri'n</u> Due to (or as			nfeton				
Box 6	e death certif he attending ied for use a	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Feta	I death 3	iEctopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
rds, P.O.	w requires that the been signed by I should be detach	ed by Ph	Part II. Other significant conditions 170 Bust Car	contributing to death t	out not res	ulting in the ur	nderlying cause give	en in Part I.		tobacco use contribute Yes 2 No 3 1	to the cause of death? Probably 4 (Munknown
Vital Records,		Complet							24a. Was auto perfo 1 \(\text{Yes}	psy prior to ormed2 death?	autopsy findings available completion of cause of as 2 \(\text{No} \)
·Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2	ER/Outpatien	t 3□ DOA Oth	/	f Death <i>(Check only i</i>	one) idence 6 □Other (Sp	necify)
o uc	ding Phys I. After this funeral di	tion: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigate	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury	Wor	vat k? Yes 2 □ No		how injury occurred	
Division of	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not determine	be on Diana of In	jury - At ho tc. <i>(Specil</i>	ome, farm, str	eet, factory, office		28f. Location ((Street and Number or I wn, State)	Rural Route Number,
	To tha Hospital within 24 hours a To tha Funeral I completely filled	edical C			of examina					cause(s) and manner date and place, and de	
	To thi within To thi	Me	29b. Signature and title of certifier	01			29c. Licens	e number		29d. Date signed (Mo.	
	6		30. Name and address of person wh	o completed cause of	death (Item	n 23a) (Type,	Print) 10UNTR	-1 yel	Ane, Ba	lt 2121	7
	Sta Regist	ate rar	30. Name and address of person when DAR SMAN S. 31. Date filed (Month, Day, Year) NOV 3 0 2	006 3 Regist	rar's Signa	Hure Appl	rate	V			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Physician Joseph M. Wood, Sr. November 25, 2006 6:00A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Future Care Nursing Home Clinton Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Dec 25, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** XXM 2□F Maryland 74 220 38 3742 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 28a-f show r than "netural", or items 23a or 28a-f sho 1 ☐ Yes 2XXNo Clinton MD Prince George's Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 United States 8625 Dangerfield Place within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1√73/Yes 2 □ No IFY0s, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Marned Korean Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐No 2 White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Tank 12 Installer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Health and Mental H lant: If item 27 Is marked otl Linda Viola Soper Thomas Edgar Wood, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha J. Wood (Wife) 8625 Dangerfield Place, Clinton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov 29, 2006 20c. Location - City or Town, State 20a. Method of Disposition 1)∭Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny Injury or once. Cedar Hill Cemetery Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee Alexandria Ferry Road, Clinton, MD 20735 mo0257 Jaus N. Drant 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DELAENTIA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): sicien and e burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 2 No 1 🗌 Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Medical Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending within 24 hours aftar death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide 0 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar Philip Wisotsky,

30. Name of a fress of person who completed cause of death (Item 23a) (Type, Print)

MD

			1 = For State Registrar	State of Maryl	and / Depa <i>Ce</i>	artment of H rtificate of I	lealth and N Death		gien g Rag. No.	2006	38101	
			1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of Death	
	Physicia /Medic		John Wells					NOv 23		006	9:50P M	
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		County of Death			
	Funeral Director		Southern Marylan 5. Social Security Number 6. Security Number		yrs. last birthday) 4 Yrs.	Clint If Under 1 Year Months Days	ON If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da June	th Year)	rince 9. Birth 932 New	George's place (State or Foreign intry) Jersey	
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	how		10a. State 10b. County		. City, Town or Lo	ocation					10d. Inside City Limits	
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	th with the 23a or 20	rai Director	10e. Street and Number 4306 Will Str	eet		10f. Zip Code 207	43			zen of What Cou		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Inportant: If item 27 is marked other than "netural", or items 23a or 28e-f show eny finjury or other treumatic event, the Medical Examinat must be notified at all ODGs.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed	12. Was Decedent Ever in Armed Forces? 1/ XYes 2 □ No lif Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	-	14. Race - Amer Black, White Specity:		
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Maryland	d be f	o Be	John Wells					ie Sibre		obmane,		
<u> </u>	shoul of Me mark	ဥ	19a. Informant's Name/Relationship (T)	γρe, Print)	19b. Mailii	ng Address (Street				r Town, State, Zi	p Code)	
Ž	nd 2: alth ac 27 le r treu		Dorothy Slocumb (Sister)	501	North Oc	ean Stree	et, Jack	sonv	ille, F	1 32202	
Je,	s 1 a of Hea itam othe		20a. Method of Disposition		b. Place of Dispo	sition (Name of matory or other place	Nov 29	Pat 2 006	20c. Lo	cation - City or T	own, State	
Ĕ	Page nent c int: If iry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,			Veterans		7	Che	1tenham	, Maryland	
Baltimore,	permit. Departr Importa eny injk		21. Signature of Funeral Service License		22	2. Name and Address lexandria	ss of Facility Lee	e Funera			6633 01d 0735	
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Sic	ttend death tor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	200 Place of laive	At home form at		Yes 2 No	29f Location (Street	d Number of Due	al Route Number,	
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	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 Acertifying Phy (Check only one)	sician: To the best of my inar: On the basis of examand manner stated.	best of my knowledge, death occurred at the time, date and place asis of examination and/or investigation, in my opinion, death occurrer stated.			and due to the red at the time.	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
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10	+17		30. Name and address of person who c									
IV	1		B. Patel, M			oad, Clin	ton, MD 2	20735				
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State of Maryland / Department of Health and Mental Hygien

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1	Funera Directo
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at
į	Physiciar /Medica Examine
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. \textstyle To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1 - State Registrar Certificate of Death Reg. No. 2000							001	0 2				
		1. Decedent's Name (First, Middle	e, Last)					2	2. Date of Dea			3. Time of D	eath
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/Medic	_	4a. Facility Name (If not institution	n, give street and no	ımber)		4b. City, Town, or	Location (4c. County	of Death		
Examin	er		kory Ave		Baltimo			ore				/A	
		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthdav		If Under	2/1 Hre 0	3. Date of Birth	1		lace (State or I	Foreian
Funeral		218-10-8977	1 □ M X XF		6 Yrs.	Months Days Hours Min. (Month,			Month, Day	30, 192	Coun	ryland	or orgin
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or 2	Director	10e. Street and Number				10f. Zip Code	24.2	4.4		10g. Citizen of		itry'?	
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er m	Funeral	11. Marital Status	12. Was De	cedent Ever in U. orces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Or an, Mexica	igin? (<i>S</i> pe <i>c</i> n, Puerto R	ify Yes or No- ican, etc.)	14. Rad Blad	ce - America ck, White, o		
or if		1 □ Never Married 2 □ Marr	If Yes, G			1 ☐ Yes 2 No	Specify:			Specif	v: wh	ite	
Exa.	d by	3 XXVidowed 4 ☐ Divorced	Year or	Dates:							WII	116	
natu	Completed	15. Deceden (Specify only highe	t's Education st grade completed)	16a. Dece (Give	edent's Usual Occup e kind of work done o DO NOT use retired	ation during mos	st of working	,	16b. Kind of B	usiness/Ind	dustry	
an .	ā	Elementary/Secondary (0-12)	College	(1-4or 5+)									
er th	Ö	10			Prir	nter Opera					ting 1	Press	
veni veni	Be (17. Father's Name (First, Middle,	,				18. Mothe			Maiden Surnar	,		
Aent rked tic e	ဥ	Norman Edward S	Sloat					Jeani	nette A	Alice Ma	ann		
uma uma		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mail	ing Address (Street	and Numb	er or Rural	Route Numbe	r, City or Town,	State, Zip	Code)	
ulth a 27 k 27 k r tra		Janet Young	Daught	er	1309	Morling	Avenu	ie Ba	ltimor	e, Mary	'land	21211	
tem othe		20a. Method of Disposition				osition (Name of	>	Da	te	20c. Location	City or To	wn, State	
		XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)										arvlano	a.
ntan njun		4 Donation 5 Other (Specify) Lorraine Park Cemetery 12/2/2006 Woodlawn, Maryland 21. Signature of Eneral Service Licensee 1 22. Name and Address of Facility											
Department of Health and Mental Hygiene. Department of Health and Mental Hygiene, and protective it it may be notified at any Injury or other traumatic event, the Medical Examiner must be notified at once.		Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211											
		- (Hamp	- alepen	w		3631 F	alls	Road	_Balti	more. M	aryla	100 212	11
- 3		23a. Rant 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										en	
ysician		Immediate Cause (Final disease or condition	2	Deme	entie	2.		,				Onset and De	auı
Medical		resulting in death)	Due to	(or as a conseq		1 1	1.1						
aminer			b. ———	Atthe	MASC	levotic	Va	scul	Cur ()	is eas-	e.		
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ansit	E.	Cause (Disease or injury that initiated events											
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iding se a		IF FEMALE:	23c. If yes, o	utcome of pregna	ancy					334 Da	ite of delive	an.	
atten for u	ian	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy □ Other (specify)						Day Ye	ar			
the	Physician	1 □ Yes 2 ➡No 9 □ Unknown	9⊟Unk	nant at time of d nown	leatii 5								
d by etac	Ph	Part II. Other significant conditi	one contributing to	death but not res	ulting in the	underlying cause give	on in Part	1	23a Did to	23e. Did tobacco use contribute to the cause of death?			ath?
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rect	o B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	EB/Outpatia	ent 3 DOA Oth	or.			ence 6 □Oth	(0		
r this		27. Manne of Death		of Injury	28b. Time					ow injury occur		<i>y)</i>	
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deatl Stor: / the	ical	3 Suicide 6 Could	not be 280 Plac	e of injury - At ho	ome farm st	treet, factory, office			Rf Location /S	treet and Numb	ner or Rura	il Route Numbe	ar.
after Dire in by	Certification	4 ☐ Homicide determ	lined buil	ding, etc. (Specil	<i>(y)</i>	,,,			City or Tow			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical		Examiner: On the	basis of examina		nvestigation, in my o							
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≥ 6		25b. Signature and the of certifie	12 T			200. 2.001.0		-10	-	od. Date Biglie	0 10	Day, rear	
V		Pully	U. Jo	J L	1U	1)35	54.	LU		11/02	710	ويال	
		30. Name and address of person	who completed car	death (Item	n 23a) (Type	Print) 00	20	$\overline{}$	A/	00-	7	1211	
		BeTSY A.	1-A4	_3/.	3 <u>Q</u>	talls !	KD	5	14010	rrin	\propto	1011	
Sta		31. Date filed (Month, Day, Year)	12.	Registrar's Signa	ature	2			•				
Registr	ar	State 31. Date filed (Month, Day, Year) 22. Registrar's Signature egistrar 40. 3 0 2006											

			For State	e of Maryland	/ Depa	rtment of H	ealth and N	Mental Hyg		
		_ 1	State Registrar		Cer	tificate of L	Death	Re	eg. No.2001	5 38103
П	Dhuaiair		1. Decedent's Name (First, Middle, Last)					Date of Deat Month	h Day Yea	3. Time of Death
	Physicia /Medic	al -		Roy A. Wi	tt			Novembe		
	Examin	er	4a. Facility Name (If not institution, give street and	·		4b. City, Town, or			4c. County of De	
			Shady Grove Advent 5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year	ockville If Under 24 Hrs.	8. Date of Birth	9. E	gomery irthplace (State or Foreign
	Funeral Director		058-24-2561 1X M 2□		Yrs.	Months Days	Hours Min.	(Month, Day, August 4	Year)	New York
			Usual Residence of Decedent							
	show dat	_	10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ne Ma 8a-f s	Director	Maryland Montgomer	У		10f. Zip Code	01ney	1	0g. Citizen of What	
	with ti		10e. Street and Number			Tot. Zip Code		,	-	
	eath rs 23 must	Funeral	3800 Mount 01r	Decedent Ever in U.S.	13. \	Was Decedent of Hi f Yes, specify Cuba	20832 ispanic Origin? (S)	pecify Yes or No-	14. Race - Ar	ed States nerican Indian,
	fter d r iten	ᇤ	1 Never Married 2 Married 1 1	ed Forces? Yes_2∭ No				o Rican, etc.)	Black, Wi	nite, etc.
2-0036	filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or items 23a or 28a-f show snt, the Medical Examiner must be notified at	b	3 N Widowed 4 □ Divorced Year	s, Give or Dates:		1 □ Yes 2 🔯 No	Specify:		Specify:	White
ည	72 hc 'natu	Completed	15. Decedent's Education (Specify only highest grade comple	eted)	16a. Deced (Give	lent's Usual Occup kind of work done of DO NOT use retired	ation furing most of wor	king	16b. Kind of Busines	ss/Industry
7	vithin ne. han " e Me	ld m	Elementary/Secondary (0-12) Colle	ege (1-4or 5+)					Dofonco	Department
22	iled v Hygie ther t nt, th	8	17. Father's Name (First, Middle, Last)	4	<u>r</u>	lectrica.			Maiden Surname)	Department
and	uld be f fental I rked of	o Be	Frank	Witt				Elsi	ie Maurer	
Maryland	should I and Men s marke umatic (ှင	19a. Informant's Name/Relationship (Type. Print		19b. Mailir	ng Address (Street	and Number or Ru		r, City or Town, State	e, Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Dianne L. Cannon/ Day	ughter	380	0 Mount	Olney Lai	ne, Olney	y, Marylar	nd 20832
Š.			20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal	from State	ace of Dispo metery, cre	sition (Name of matory or other place gomery	ne) Dog	Date ember	20c. Location - City	or Town, State
Ĕ	Pages ment of ant: If its ury or o		4 ☐ Donation 5 ☐ Other (Specify)	C	remato	rium Inc	. ; 3,	2006	Bethesda	, Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	/ / M003	35	Rockvill Rockvill Rockvill	e, Inc. Mary 1	pert A. I 300 West and 20850	Pumphrey I Montgomer N-2805	Funeral Home/ Ty Avenue
	7-36		23a. Part1. Enter the disease, or unit locations shock, or heart failure. List only one cause	that caused the death	. Do not en	er the mode of dyin	g, such as cardia	or respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final	ntracrania	1 Hemo	rrhage N	ontramati	ic		Onset and Death Davs
	/Medical			ue to (or as a consequ						
B	Examiner		Sequentially list conditions, b. H	ypertensiv	e Athe	rosclero	tic Vascı	ılar Dise	ease	Years
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	de to (or as a consequ	ence oi).					
	xecut and	Examiner	that initiated events c	ue to (or as a consequ	ence of):					
760,	e be e	dical E								
89	tificat ig phy as the	ledi								
Box	th cer tendir r use	Physician/Me	23b. was decedent pregnant	s, outcome pf pregna Live birth 2 □ Fetal		☐Ectopic pregnancy	/		23d. Date of Month	delivery Day Year
Е	e dea the att	sici		Pregnant at time of de Unknown	eath 5[Other (specify) _			I WORKI	Day
P.O.	hat th d by 1 setack		Part II. Other significant conditions contributing	to death but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
Records,	signe d be d	d by	,		Ü	, 0		1 □ Y	′es 2 ∑ No 3□	Probably 4 Unknown
S	w requ	Completed						24a. Was a	an 24b. Were	autopsy findings available
æ	he lar e has age 2	E C						autop: perfor 1∐ Yes	rmed? death	to completion of cause of n? ′es 2 □ No
	an: T tificat tor, pa	Be Co	25. Was case referred to medical				26. Place of De	ath (Check only of	-2x	63 2 110
or Vital	nysici lis cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	1 X Inpatient 2 □	ER/Outpatie	nt 3□ DOA Oth	er: 4 Nursing F	dome 5 ☐ Resid	lence 6 Other (S	pecify)
0 _	ng Ph fter th neral	Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe h	ow injury occurred	
Sio	tendil eath. or: A the fu	catic	2 Accident investigation				Yes 2 ☐ No	005 1 10 /0	Name & a med Alexandra as as	Rural Route Number,
Division	al or Att	Certification:	4 Homicide determined	Place of injury - At ho building, etc. (Specify	me, tarm, st	reet, factory, office		City or Tow		Hurai Houle Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (the basis of examina d manner stated.	tion and/or i	nvestigation, in my	opinion, death occ	urred at the time,	date and place, and	due to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	1 1		29c. Licens	se number	2	29d. Date signed (M	onth, Day, Year)
	,		Hercia J. A	usery	MB	05	9738	1	Novemb	per 23, 2006
	15		29b. Signature and title of certifier Plicia J. M 30. Name and address of person who complete Alicia Mistry 31. Date filed (Month, Day, Year) NOV 3 0 2006	d cause of death (Item 9901 M	23a) (Type	Print) al Conte	rbrive	2 Rock	wille, M	D 20850
		ate	31. Date filed (Month, Day, Year)	32. egistrar's Signa	18 A	MALE				
	Regist	rar	NOV 3 0 2006	PARELES I	-//					
	DEATH ARE DO NOT									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NZ 0 0 6 Certificate of Death nt's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year MIC 0,25 PM AMS 2006 /Medical Location of Death 4c. County of Death acility Name (If not institution, give street and number, Town, of Examiner mor (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min 1 ■ M 2 12 Director land nare Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ms 23a or 28a-f shov must be notified at 1 Nes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 12. Was Decedent Eyer in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc Affiled Folces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 2 1 No Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☐ No Specify ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) akce Department of Health and Mental Hygie Important: If Item 27 is marked other i any Injury or other traumatic event, tt once. 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) ပ unknown ankarın 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Makel hambers noi lamont in 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signatur Juneral Se vice License 22. Name and Address of Facility Horse march 23a. Part1. Er e the disease, or com disease, Approximate Interval Between Onset and Death tions that caused the dyath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate use (Final disease or condition resulting in death) **Physician** /Medical Examiner gaper lially list contained; if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) þ nditions contributing to death but not regulting if the underlying use given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has the rector, page 2 s autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 Depatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Watural 2 Accident 1 ☐ Yes 2 ☐ No Director: Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 124 hours after le Funeral Dire pletely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2506 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reyn Back more St Howard noldo Bacto, MD 2000 w, 21223 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Marylar		epartment of F Certificate of		lental Hy	/giene Reg. No.	IIIIh	38105
	Physici	an	Decedent's Name (First, Middle, Last DIFALLON	•				2. Oate of Do Month	Day	y Year	3. Time of Death
	/Medic	cal	O'FALLON 4a. Facility Name (If not institution, give			4h City Town o	r Location of Death	NOV.	26	County of Deat	
	Examin Funeral Director	ier	5. Social Security Number 6. Sr 428-46-9061	OF BALDIM	last birth	E BAU	More 14 Hrs.	8. Date of Bi (Month, D. October	rth	9. Birt	hplace (State or Foreign untry)
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. Cit	v. Town	or Location					10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f ehow ricust be rediffed at	to	Maryland Baltimor		vson						1 □ Yes 2 No
	th the	lrec	10e. Street and Number	<u>e</u> 100	N3011	10f. Zip Code			10g. Citi	izen of What Co	
	23a c	aiD	1055 West Joppa Ro			21	204			USA	
) ~ / かしい ~ Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or items 23a or 28a-1 ehow array injury or other traumatic event, itta Modical Examinational be retified at once.	d by Funeral Directo	11, Marital Status 1 □ Never Married 2 □ Married ★XWidowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates:		1 □ Yes XX No	an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White Specify: Wh	e, etc.
3 1	in 72 t	ojete	15. Decedent's Ed (Specify only highest grades)	de completed)	16a. I	Decedent's Usual Occup (Give kind of work done i life. DO NOT use retired	ation during most of worki d)	ng	16b. Ki	ind of Business/	Industry
691200A	d withing and withing with an archard	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		RN/Teacher	-,		Pr	ivate S	chool
1 2 E	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			,	
S S	d Men narke	ဥ	Phillip Y Ray 19a. Informant's Name/Relationship (7)	Supp. Oxinti	405	Mailing Address (Street				Fisher	
on,	and 2 si Balth an m 27 le r		Kathy Sharon Bingl	ey DTR	72	2 Shelley R					up Code)
<i>W」LSO</i> [∞] altimore, M	. Pages 1 tment of H tant: If iter		20a. Method of Disposition 1 □ Burial XXX emation 3 □ □ Donation 5 □ Other (Specify	Removal from State Gre	emetery	Disposition (Name of c, crematory or other place ount Cremat	ory 11/30		Balt		Maryland
Ball	permit Deper Impor any in		21 Signature of Funeral Service Licent	m Kenaki	1	22. Name and Addres	ss of Facility Mitc ork Road I				
			23a. Part1. Enter the disease, or composhock, or heart failure. List only of	olications that caused the deat	h. Do no						Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Complication			we ffor	CTURE	0	Nuter .	Onset and Death
	Sit All	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq	uence of	f):			BY WENT	EO.M.	
ć	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	uence of	f):		ON PROVED	Bi		
68760,	ate be hysicia the bu	edical	(d			CERTIFIC	See.		3	
	entific ding p		IF FEMALE:	23c. If yes, outcome of pregna							
Division of Vital Records, P.O. Box	Attending Physician: The law requires thet the death certil rideath. rideath. ector: After this certificete has been signed by the attending by the funeral director, page 2 should be detached for use a by the funeral director.	Physician/M	23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 No 9 ☐ Unknown	4 Pregnant at time of d	I death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			2	23d. Date of deli Month	very Day Year
ω <u>΄</u>	s thet gned b	by PI	Part II. Other significant conditions co	ontributing to death but not res	ulting in	the underlying cause give	en in Part I.	23e. Did 1	obacco u	se contribute to	the cause of death?
ord	w requires thet s been signed t s should be det		typertension,	DIABETES	11	4-perlipit	mia	1 🗆	Yes 2	No 3□Pro	bably 4 Unknown
l Rec	The law rete has by page 2 sh	Completed	Demy a)	61 te	σρο	roi is		24a. Was auto perio 1 Yes	an psy prined? 28 No	prior to c death?	topsy findings available ompletion of cause of
Vita	ysician: The iis certificete ha director, page	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death				
of	Phys r this ral dir	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outp		4 Nursing Hon	ne 5 ☐ Resi 28d. Describe			ify)
<u>.o</u>	nding lath. r: After e funer	atior	1 ☐ Natural 5 ☐ Pending investigation	(Month, Day Year)	lnj	me of 28c. Injury Work		60 Km	2M 4	SLANDI	~~
Ν	or Attendi siter death. Director: A in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. lace of Injury - At he building, etc. (Specif	me, farr		1 2	28f. Location (City or To	Street and	d Number or Ru	ral Route Number,
D	pltat o	Cel			vry	PAROR	1	355U	V.J	oppa 14), lowson'
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier Check only one)	ysician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, tion and	oeath occurred at the time for investigation, in my of	ne, date and place, a pinion, death occurre	and due to the ed at the time,	date and	arld manner as place, and due	statéd. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	-0.0		29c. License	e number		29d. Date	e signed (Month	, Day, Year)
	d.		30. Name and addless of person who d	completed cause of death (free	2201 /7	Type Print	17334	200	11/2	8/06	- (D) A -
	10		B. SHAR	M. SINA			nome	_ 3A	W. 1	BELVE	DEEL AVE
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	0-5					
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** A M 0121 IERRIA NOUZMRER 2000 /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner LiMORE John Birthblace (State or Foreign Country) Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral Days Months 1 M 2 F Director Usual Residence 3508c120 May 30, 1992 Marvland filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No **Funeral Director Baltimore** Maryland Street and Number 10g. Citizen of What Country? 10f. Zip Code 10e. 4016 Woodhaven Avenue
arital Status

□ Never Married 2 □ Married
□ ¥irlowed 4 □ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?
1 □ Yes 2 □ No
If Yes, Give
Year or Dates: X 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Rlack 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) the **Baltimore City School** i. Pages 1 and 2 should be filed wirtment of Health and Mental Hygien tant: If item 27 is marked other the jury or other traumatic event, the High School Student
18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nam8(First, Middle, Last) ဂ္ Penny Baxter James Young 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland 21216

20c. Location - City or Town, State Penny Baxter Mother 20a. Method of Disposition Baltimore, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If 4 Donation 5 Other (Spegify) 12/02/06 Lansdowne, Maryland Mt. Zion Cemetery Facility 21. Signature of Funeral Service Licent Estep Brothers Funeral Service P A Puni. Enter the diseas, or complications that caused to leath. Do not enter the moda@diffcutawaPlace Baltimorey Mod 21217 shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HYPERKALEMIA hours /Medical Due to (or as a consequence of) Examiner upus SISTEMIC ERYTHEMATOUS months Sequestially list nondillors if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-trai Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. the a 9□Unknown 9 JUnknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No Pancreaditi 1 Tyes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an Autoinmure Hendutic certificate has page 2 s lutopsy performed death? 1 ☐ Yes 2 No 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1% Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated 29c. License number 29d Date signed (Month, Dav. Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

GOON. WOLFE

STREET

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAMSON

31. Date filed (Month, Day, Year)

Vouense

BALTIMORE

			1 - For State Registrar	State of Marylan		artment of F			ene 006 g. No.	38107
	Physicia	an	Decedent's Name (First, Middle, Last) Mavis	0.	Arch	ambault		2. Date of Death Month	Day Year	4.4
,	/Medic Examin		4a. Facility Name (If not institution, give st		AICH		Location of Death	October	26 2006 4c. County of Dea	9:03 a [™]
	Funeral Director	eı	Morningside House 5. Social Security Number 6. Sex			Hanove1	:	8. Date of Birth (Month, Day, April 2	Anne A	
	pu .		Usuel Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo					
	Manyla f ehov	ō	MD Anne Arur		Hanov					10d. Inside City Limits 15☐Yes 2 ☐ No
	r 28a-	rect	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	
	death with the Maryland me 23s or 28s-f ehow rights be notified at	aiD	7548 Old Telegraph	n Road, Apt.	103	2107	5		USA	
0000	permit. Pages 1 and 2 should be filed within 72 hours elter death with the Marylan Depertment of Heelih and Mental Hygiene. Depertment of Heelih and Mental Hygiene. Importent: if item 27 is marked other than "natural; or iteme 23a or 28a-1 show eny injury or other treumatic event, the Mudical Examinat must be multiled at once.	by Funeral Director	11. Marital Status 12 Married 3 Married 3 Midowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
N-C1717	l within 72 ho iene. r than "natu	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12) 12	ation completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usuaf Occup kind of work done DO NOT use retired taker	ation during most of work t)	king	6b. Kind of Busines Own Home	s/Industry
p	e filed al Hyg other	BeC	17. Father's Name (First, Middle, Last)		,	-	18. Mother's Nam	ne (First, Middle, M		
yland	Menta arked atice	ToE	Lars O. Valsvik	· · · · · · · · · · · · · · · · · · ·				arlson		
Mar	12 sh h and 7 te m treum		19a. Informant's Name/Relationship (Typ Donna Dudderar (Fi						City or Town, State,	
ā,	Heeli Heeli tem 2 other		20a. Method of Disposition			sition (Name of natory or other place			• MD 2111:	
Ē	Pages nent of nnt: ff i		1 XBurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	illoval Ilom State		natory or other piac . Nat. Cei	,	5-2006	Arlington	. Va
Baitimor	permit. Depertn Importe eny injt		21. Signature of Funeral Service Ligensed	•	22	Name and Address Hardesty 851 Anna	7 Funeral	Home, P		
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat cause on each line.	h. Do not ent					Approximate Interval Between
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Alienosclero	tic CA	RDIOVASCU	LAR D	SEASE		Onset and Death
	Examiner			HYPERTEN.	uence of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a conseq	701-				*	
68/60,	ificate be executed g physicien and as the burial-transit	ai Exa	resulting in death) Last	Due to (or as a conseq	uence of):					
_	rtificati og phy as the	Aedicai	U.							
.c. Box	w requires that the death certif been signed by the attending should be detached for use as	ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▷ No 9 □ Unknown	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	ıfdeath 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	ofivery Day Year
cords, F	requires that the	d by PI	Part II. Other significant conditions cont PNEUMON/A	ributing to death but not res	uiting in the u	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 Unknown
Heco	The law re ste hes bee page 2 sho	ompleted by Phys	CONGESTIVE +	YEART F	ALLUI	2F		24a. Was an autopsy perform	prior to death?	
VII	ilan: artifice ctor, p	Be C	25. Was case referred to medical examiner?				26. Pface of Dea	th Check only one	Z No 1 ☐ Ye	s 2D No
5	hyaic this ce	၉	1 ☐ Yes 2 ☒ No	ospitaf:			4 Li Nursing H		nce 6 Other (Sp	ecify)
DIVISION	ending F sath. or: After he funera	ertification:	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 ⊡No	28d. Describe hor	w infury occurred	
Š	tel or Att rs after d af Direct ed in by t	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pface of Injury - At he building, etc. (Specif	ome, farm, str fy)	reet, factory, office		28f. Location (Str City or Town,	eet and Number or F State)	Rural Route Number,
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edicai	29a Certifier (Check only one) L.Certifying Physical Check only 2 Medical Examin	er: On the basis of examina and manner stated.	wladga deat ation and/or in	restigation, in my o	ra date and place pinion, death occur	and due to the car rred at the time, da	use(s) and manner s te and place, and du	e to the cause(s)
	To t To t	Ž	29b. Signature and title of contifier			29c. Licens		29	d. Date signed (Mor	nth, Day, Year)
			lland Tresser	Jun			5134	/	1/3/06	
	5		30. Name and address of person who cor Carol Pressey				. Ste 101	- Fdgara	ter, MD 2	1037
į,	Sta	te	31. Date filed (Month, Day, Year)	32. Pogistrar's Signa		1 00	, 555 101	, Lugewa	cor, rm Z	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38108 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2006 November 6, 12:25 AM MILDRED AMENT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise of Columbia Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 2 2 X 216-40-6622 94 28, Director Aug. 1912 Maryland Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ont if item 27 le marked other then "netural", or iteme 23s or 28s-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show Maryland Director Howard Columbia 1 Yes 3 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6500 Freetown Road, Apt. 324 21044 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner 1 ☐ Yes 2/XNo If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3€Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home f Health and Mental Hygitem 27 le marked othe other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Joseph Burger Mary Gertrude Reilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Flores/daughter 8007 Brooklyn Bridge Rd. Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of F Importent: If ite eny Injury or ot ance. 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Vets. Cemetery 11/9/2006 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral \$ 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ADVANCED DEMENTIA 7=115 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Tany, leading to infraction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to für as a consecuence off Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2 7 No 25. Was case referred to medical 26. Place of Death (Check only one) Assisted Living Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6200ther (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending efter death.

Director: Aff
In by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by

4 Homicide

🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

CHAMPA Dr

200

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tyle of certified 29c. License number 40 D0051860

FISH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOKATHAN

29d. Date signed (Month, Day, Year)

COLUMBIA

November 6, 2006

21044

State Registrar

Medical

29a. Certifier

31. Date filed (Month, Day, Year) NOV 0 9 2006



no



within 24 hours e To the Funerel (Hospital

Certificate of Death

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed signed by the el should should certificate After thi funeral of Director: / d in by the f within 24 hours after To the Funeral Dire

Be

2

Certification:

cai

1 - For State Registrar

State Registrar D.O.

5 Pending investigation

6 Could not be determined

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 ☐ Yes 2 🔀 No

27. Manner of Death

1 Natural

2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number H44828

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 11/15/06

Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

3 Probably 4 □Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No

1 ☐ Yes 2 ☐ No

2 X No

28d. Describe how injury occurred

21811

24a. Was an autopsy performed?

1 Yes

Other: 4 Nursing Home 5 Nesidence 6 Other (Specify)

26. Place of Death Check only one

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

314 Franklin Ave. Berlin, MD

3 DOA

31. Date filed (Month, Day, Year) NOV 1 5 2006

prookulen

idea 32. Pegistrar's Signature

2 ER/Outpatient

28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

28b. Time of

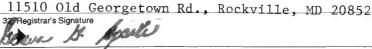
10

State Registrar 29b. Sign

31. Date filed (Month, Day, Year) 15 2006 NOV

G. Peter Pushkas, MD,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

D21531

29d. Date signed (Month. Dav. Year)

November 14, 2006

			1 - For State Registrar	State of M	Maryland / Dep Co	partment of Fertificate of	lealth and <i>Death</i>		iene 00	38111
			Decedent's Name (First, Middle, Last	1)				2. Date of Dear	th	3. Time of Death
Н	Physici /Medio		Terrell	Jane	Br	iggs		Novemb	er 4 200	
	Examin		4a. Facility Name (If not institution, give	street and number		4b. City, Town, o	r Location of Dea		4c. County of D	
			4 Thorn Court			Annap	olis		Anne	Arunde1
	Funeral		5. Social Security Number 6. Se		Age (In yrs. last birthda		If Under 24 Hi Hours Mi			Birthplace (State or Foreign Country)
	Director		214-00-1411	□M 2√2 F	53 Yrs.		1100.0	Oct 3 1	953 Mi	cronesia
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation				10d. Inside City Limits
	Aaryt	ō		3 1						1 ☐ Yes 2 No
	28e-1	Director	MD Anne Aru 10e. Street and Number	ndel	Annapo	10f. Zip Code			0g. Citizen of What	
	with Ba or	0	4 Thorn Court			· ·	03	'		Country :
	death ns 23	era	11. Marital Status	12. Was Decede	nt Ever in U.S. 13	Was Decedent of H		Specify Yes or No-	USA 14. Bace - A	merican Indian,
(0	r iter	by Funerai	1 ☐ Never Married 2 ☐ Married	Armed Force 1 ☐ Yes 2√	s? XNo	. Was Decedent of H If Yes, specify Cuba		erto Rican, etc.)		/hite, etc.
ဇ္ဇ	el', o		3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Dates	s:	1 ☐ Yes XX No	Specity:		Specify:	White
2	within 72 hours after death with the Maryland ene. then "naturel", or items 23s or 28e-f show the Modical Exacultur Lual be notified at	Completed	15. Decedent's Edu (Specify only highest grad	ication	16a. Dec	edent's Usual Occup	ation	ndkina	16b. Kind of Busine	ss/Industry
7	ithin	np.	Elementary/Secondary (0-12)	College (1-4c	Of 5+)	re kind of work done of DO NOT use retired	d)	one of the original of the ori		
2	ygier ygier her th		12		Boat	Builder			Boat Bui	lding
and	be fi	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle, M	Maiden Sumame)	
ž	d Mer d Mer nark	ဥ	Charles Frederick 19a. Informant's Name/Relationship (T)					. Buckner		
Maryland 21215-0036	d 2 sl th an 7 ie r traur		David Manning (Fr					Rural Route Number olis, MD		e, Zip Code)
ė,	1 an Heeli em 2		20a. Method of Disposition	rend)	20b. Place of Dis	position (Name of		Dean Control	21403 20c. Location - City	or Town State
2	ages ont of t: M it		1 ☐ Burial 2 XCremation 3 ☐ I		te cemetery, ci	ematory or other plac	11-	-7-06	,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28e-f show any figury or other traumatic event, the Modical Examinar mast be nutified at ODCe.		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Fune/al Service Licens		Metro Ci		ss of Facility		Baltimore	, MD
Ba	Dep imp		Natil 1	////		Hardesty	Funera	1 Home, P. ue, Annapo	A.	21401
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caus	ed the death. Do not e					Approximate
	Physician		Immediate Cause (Final	ne cause on each	n ine.	^	N WG			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or a	as a consequence of):	· Co De () VO(3~173		syears
1	Examiner		Commentally the ties and deliver	b	. ,					
	D #	ner	if any, leading to immediate		as a consequence of):					
	nd	Examiner	Cause (Disease or injury that initiated events	с.						
Ŏ,	se execien a	Ë	resulting in death) Last	Due to (or a	as a consequence of):					
8760,	ficate be executed physicien and is the burial-transit	dicai		d						
9 ×	ding	Physician/Me	IF FEMALE:	23c. If yes, outcon	ne of prognancy				77	
Вох	etten for u	ian	in the past 12 months?	1 ☐ Live birth	2 Fetal death 3	☐Ectopic pregnancy			23d. Date of Month	delivery Day Year
oʻ.	the d	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9☐ Unknown		Other (specify)				
۵.	The law requires that the death certifi tie has been signed by the ettending bage 2 should be detached for use as		Part II. Other significant conditions co	ntributing to death	but not resulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Records,	quires n sign	d by						1/X/Ye	s 2 🗆 No 3 🗇	Probably 4 Unknown
00	s been si should	Completed						24a. Was ar	24b. Were	autopsy findings available
H	The tav	E O						autopsy	nyeon?∣ death	autopsy findings available to completion of cause of
ta		0	25. Was case referred to medical				26 Place of De	1 ☐ Yes 2 eath Check only one		es 200 No
>	S w D	To B	examiner?	Hospital: 1 ☐ Inpa	tient 2 ER/Outpati	ent 3 DOA Othe		1	nce 6 □Other (S	pecify)
0	ding Ph h. After th funeral		27. Manner of Death	28a. Date of In (Month, D	njury 28b. Time Day Year) Injury	of 28c. Injury Work	at	28d. Describe ho		
<u>S</u>	Attending r death.	catic	2 Accident investigation				Yes 2 □No			
Division of Vital	after deat Director:	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	njury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location (Str City or Town	reet and Number or , State)	Rural Route Number,
	ospital or hours at unerei D		200 Continue And a	1						
	± 2 m 5	Medicai	29a. Certifier 15 Certifying Phy (Check only 2 Medical Exami	sician: To the bes ner: On the basis and manner:	st of my knowledge, dea of examination and/or	ith occurred at the tim nvestigation, in my op	ne, date and place pinion, death occ	e, and due to the ca curred at the time, da	luse(s) and manner ite and place, and d	as stated. lue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		A N	29g. License	number /	1 29	od Date signed (Mo	ngth, Day, Year)
	->-0		* Valence	1/ 15/0	JUS		01/0	4 11	1001	1
			30. a and address of par on who co	ompl Luse N	Ideath Iltem 23al Styre	-Rrint	200	_ A	COLO	
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	Registr	ar	NOV 0 9	2006 🚜	manage of the same	Mary B				

DHMH 17 Rev 1/2001

	_ 1	For State Registrar	State	of Maryland		ırtmen <i>tificat</i>					giene (006	381	12
5 1		1. Decedent's Name (First, Middle,								2. Date of Dea Month	ath Day	Yeer	3. Time of	
Physicia /Medic	al	NINIAN		eAll_						NOV.	5	2006	1:10	Рм
Examin		4a. Facility Name (If not institution,						Location	of Death			nty of Death		
		Oak Crest Vill			nt hirthdry)	Park If Under	vill	e If Under	24 Hrs.	8. Date of Birt		1timo:		or Foreign
Funeral		5. Social Security Number 214-05-1852	3.Sex 1∭2 M 2□ F	7. Age (In yrs. las	Yrs.	Months	Days	Hours	Min.	(Month, Da) Aug 27	v. Year)		place (State o intry) y Land	
Director	-	Usual Residence of Decedent								1100 -		1,		
yland		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside C	•
with the Maryland a or 28e-f show by notified at	cto	MD Anne A	Arunde1	Ar	mo1d								1 🗆 Yes	2 X NO
or 28	Director	10e. Street and Number				10f. Zip					10g. Citizen		intry?	
ath w	ra	332 Buena Vista			10.1		21012		igin? (Sn	noify Vas or No		SA Race - Amer	ican Indian	
ter dea	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed F	edent Ever in U.S. orces? 2 No	. 13. 1	f Yes, spec	ofy Cubar	n, Mexica	n, Puerto	acify Yes or No Rican, etc.)	13.	Black, White		
irs aft	by	3 Widowed 4 □ Divorced	If Yes, G Year or I	ive Dates:1940-8	31	1 🗌 Yes	2	Specity.	:		Spe	cify:	White	
72 hou neture		15. Decedent's (Specify only highest	s Education		16a. Deced	ient's Usua kind of wo	ai Occupa	ition	st of work	ina	16b. Kind o	f Business/l	ndustry	
thin 7	Completed	Elementary/Secondary (0-12)	1	(1-4or 5+)	life. I	DO NOT us	e retired))						
be filed within 72 hr Ital Hygiene. Id other than "netu event, Ite Medical	S		2		Sales			19 Moth	or's Name	(First, Middle,	Automo			
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. I amarked other than "neturel", or Items 23a or 28e-f show reumatic event, Ira Madeal Examination at be notified at	Be	17. Father's Name (First, Middle, L. Lemon Beall, J.								rr Coll		iaino)		
y lo	ဥ	19a. Informant's Name/Relationsh			19h Mailir	ng Address	(Street a		•	al Route Numbe		wn, State, Z	ip Code)	
d 2 si d 2 si th an th an treur		Thomas Beall (S				•	,			, Arnol				
Heal Heal tem 2		20a. Method of Disposition		20b. Pla	ice of Dispo	sition (Nar	ne of	a)		Date	20c. Location	on - City or 1	Town, State	
ages ant of t: Ki		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		n State	Hallo				11-8	-2006	Davids	onvil	le, MD	
permit. Pages 1 and 2 should be filed within Deparmit. Pages 1 and 2 should be filed within Department of Hadalh and Mahall Hygiene. Importent: If item 27 is marked other than any injury or other treumatic event, ITEM ODGE.	9	21. Signature of Funeral Service L	7	100						Home, P				
Depariment of the control of the con		1200.	9			12 R:	ldge1	y Av	enue	, Annap	olis,	MD 21	401	
		23a. Part 1. Enter the disease, or of shock, or heart failure. List of	complications that	ceused the death. each line.	Do not ent	er the mod	le of dying	g, such as	s cardiac	or respiratory a	rrest,		Approximation interval Bet Onset and	ween
Physician		Immediate Cause (Final disease or condition	a Er	-d stag	e in	0 00	ey (V :s.	ecs 1	?			Onsot and	
/Medical Examiner		resulting in death)	Due to	(or as a conseque	ence of):									
Lxammer	er	Sequentially list conditions,	b. — Dun to	(or as a consequ	er peroffr					<u> </u>				
ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.)	300 11	(5. 25 5 5 5 5 5 5										
be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	C. Due to	o (or as a conseque	ence of):									
The COLIDS, F.C. BOX 801000. The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cail	1	d			_								
tifical		is service	T											-
th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregnan birth 2 Tetal	death 3[Ectopic p					23d.	Date of deli	*	Year
w requires that the death certificate I been signed by the attending physishould be detached for use as the	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unk	gnant at time of dea nown	ath 5	Other (s	oecify)							
hat the deby detacl		Part II. Other significant condition	ns contributing to	death but not resul	Iting in the u	nderlying (ause give	en in Part	I,	23e. Did t	obacco use	contribute to	the cause of	death?
signe d be	d by									10	Yes 2□N	o 3 🗀 Pro	obably 4 🗂	Unknown
w requires been signe should be	Completed									24a. Was	an 2	4b. Were au	topsy findings	available
he lav e has	d mc									auto perfo	ormed?/	prior to death?	completion of a	cause of
VICION: T icion: T cortificati ector, pe	Ö	25. Was case referred to medical	10.					26. Plac	e of Deat	h Check onl				
Of VICE Physicien: this certific ral director,	0	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1	Inpatient 2 🗆 E	ER/Outpatie	nt 3 D	Oth	өг: 4 🗖 N	lursing Ho	ome 5□Resi	dence 6	Other (Spec	cify)	
ON OF VICAL MEGINATION OF LANGUAGE TO A LANGUAGE CONTRICATE HAS funeral director, page 2	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Dat (Mo	e of Injury onth, Day Year)	28b. Time o Injury		28c. Injun Worl			28d. Describe	how injury or	curred		
Attending ar death. ector: After by the fune	cati	2 Accident investig	ation			M		Yes 2	TN0	28f. Location (Street and N	umber or Ru	ıra I Route Nur	nher
lor Atlanta	Certification:	4 Homicide determi	ned 200. Fla	ce of Injury - At hor ding, etc. (Specify,	me, tarm, st	reet, ractor	у, опісе			City or To	wn, State)	<i>5/11/201</i> 07 7 10		
To the Hospitel or Attendit within 24 hours after death. To the Funerel Director: A completely (illed in by the fu	edical Co	29a. Certifier 1 Certifyin (Check only 2 Medical I	Examiner: On the	he best of my know	vledge, deat ion and/or in	th occurred evestigation	at the tin	ne, date a pinion, de	and place, eath occur	and due to the red at the time,	cause(s) and date and pla	d manner as ice, and due	stated. to the cause(s)
o the lithin 2 o the	Med	29b. Signature and title of certifier		anner stated.		29	c. Licens	e number			29d. Date si	gned (Monti	h, Day, Year)	
F ¥ F 8) h-ma	0-16-				05	X6	46		Non	embe	r 6 2	006
ب حود		30. Name and address of person	who completed ca	use of death (Item	23а) (Туре,	, Print)			1 0		~ .			
15+		Anna Moniac			Ithe	~	Bo	ileo	eno	Park	-v.110	Mi) 513	134
	ate	31. Date filed (Month, Day, Year)		Segistrar's Signat	ure	Cart								
Regist	rar	NOV 0	9 2006	THE PER !	or A									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day . **Physician** Month NOVEMBER 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner XVERNA Anne Arundel INRISE Severna Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 26 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 1 M 2 XF 80 Director 198-12-4033 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow the Medical Exeminer must be notified at 1 ☐ Yes 2 ☐ No Director Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 334 Rosslare Drive 21012 USA Funeral filed within 72 hours after death Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: þ 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coflege (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene. 12 Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hyman Olshansky Anna Rifkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heath ar Important: if Item 27 is any Injury or other trau Roxanne Krigman (Daughter) 334 Rosslare Drive, Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location · City or Town, State 1 Purial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (State) ☐Donation 5 ☐ Other (Specify) Hillcrest Cemetery 11-8-2006 Annapolis, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Liver e 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) and Death ADVANCED **Physician** DEMENTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregrant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a o. 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably been si Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy performed 1 Yes 2 No Be 25. Was case referred to 26. Place of Death | Check only one ASSISTED Hospital: Other: 4 Nursing Home 5 Residence 6 ther (Specify) UV) WG 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Director: After th 27. Mann 1 Death 1 atural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending death. investigation 1 Yes 2 No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier Voterms Horney Mussure MD21108 dress of person who completed CHA 31. Date filed (Month, Day, Year) 32. Mgistrar's Signature State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year **Physician** reooks 11:10 Am 2006 November 16 /Medical 4a Fecility Neme (If not institution, give street and number) 4b City, Town, or Location of Deeth 4c. County of Deeth Examiner Notui DRC INCYICU GLORGE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 6. Sex 1□ M 20XF Days Min. 214-32 7848 Usual Residence of Decedent Months Hours Yrs. Director dentamber 19 1935 Washington 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Phode r than "naturel", or itams 23a or 28a-f eho the Medical Evantiner must be notified at 1 ₽Yes 2 No PRINCE Directo Accoked MARYLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2060° filed within 72 hours after death DUR 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian 11. Maritel Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Giv 2 □ No 1□ Yes 20 No Specify: ģ Specify 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Georges alth end Mental Hygiene. 27 is marked other than if traumatic evant, the Me Elementary/Secondary (0-12) College (1-4or 5+) School anchae tent of Health end Mental H. It if item 27 is marked other y or other free. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 and 2 should be CWMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Lestion - City or Town, State Droon 15416 Ovcelar Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of Himportant: If ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State halfenham Macyland 4 Donation 5 Other (Specify) Maruland ETCRAN 21. Signature of Fund al Servi 22. Name and Address of Facility Adams TUNCEAL Home PA Road Aguasco MARYLANCI 20608 20605 Haunsen 23a. Pert 1. Enter the disease, or complications that caused the deeth. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician ANOUNCULAR DUSTUS /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as e consequence of) attanding physicien for usa as the burie Physician/Medical Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? s cartificate has t director, page 2 s 2 KNO 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Menner of Death 28b. Time of edical Certification:

Attending Physician: The law raquires that the death carlificate be executed Division of Vital Records, P.O. Box 68760. funeral Diractor: After death. aftar

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within 24 hours aft To the Funeral Di completaly filled in Hospital

Baltimore, Maryland 21215-0020

1 Naturel 2 Accident 5 Pending investigation

4 Homicide 29a. Certifier

3 ☐ Suicide

28a. Date of Injury (Month, Day Year) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and fittle of certifier

29d. Date signed (Month, Day, Year)

State Registrar

NOV 2 1 32. Registrer's Signatures

impleted ceuse of deeth (Item 23e) (Type, Print)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Ple	ase T	ype or	Print in	Black	Indelib	le Ink. I	Ensure A	III Copies	Are	Legible.		
		_ For		State of	of Maryla	nd / D	epartme	nt of He	alth and I	Mental Hy	gienę	hone	0.0	
		1 - State Registrar				(Certifica	te of De	eath		Reg. No	2005	3 6	3115
		1. Decedent's Name (First, Mid	dle, Last)		~					2. Date of De	ath		3. Тіп	ne of Death
Physicia		David J	ero	me	Bru	mm	e 11, 5	r.		Novembe	1 20		6 2	100 M
/Medic Examin		4a. Facility Name (If not instituti						y, Town, or Lo	cation of Death			County of Dea		
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Funeral		5. Social Security Number 217-30-9719	6. Sex	M 2□F	7. Age (In yrs	. last birth	Months		f Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	th y, Year)		thplace (Sta	ate or Foreign
Director		Usual Residence of Decedent				/ ["	5.			Dec. 10	, 193	4 100	aryla	nd
land ow		10a. State 10b. Coun	ty		10c. C	ity, Town	or Location						10d. Insid	le City Limits
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		1 Never Married 2 Ma]	1 Pres	2 🗆 No		1 ☐ Yes		Specify:	o moun, etc.)			Black	
2 2 44	d by	3 Nidowed 4 □ Divorce		Year or D	oates: 53-			•				Specify. E	IQCI	\
net alle	lete	15. Decede (Specify only high	enf's Educ	cation e <i>completed)</i>		16a. D	ecedent's Us Give kind of w	ual Occupatio rork done duri	in ing most of wor	king	16b. Ki	nd of Business	/Industry	
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Physician /Medical		disease or condition resulfing in death)	- a		(or as a conse		onia						Da	75
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The page	Completed									perfo	med?	death?	2 □ No	
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or All	Certification:	4 Homicide deter	mined	28e. Place buildi	of Injury - At I ing, etc. (Spec	nome, farm ify)	, street, facto	ry, office		28f. Location (S City or Tow	n, State)	d Number or Ri	ural Route ∧	lumber,
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o the	Š	29b. Signature and title of certif	ier				29	c. License nu	ımber		29d. Date	e signed (Mont	h, Day, Yea	r)
- 5-0		LVandy	ains	atha	<u></u>	M7		DOC	774			•		,
	+	30. Name and address of perso	n who co	moleted caus	e of death (Ite	m 23a) (Tu	ne Print)		' ' T	1		- γ.5ς γ	,	
		Laksha II	is du	anath	an m	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	2195	Wast	in the	5+ <	But	mber:	12/	601
Stat	е	31. Date filed (Month, Day, Yea		-	egistrar's Sign	ature	A		THE TEN		~\/	, , , , , ,	<u> </u>	
Registra	ır .	NOV 3	0 20	106	the state of	KK J	GDB4EL							

Doris Madeline Butler

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cen	Death		Re	eg. No. 200	6 38116	
Physicia	an/	 Decedent's Name (First, Middle,L 					Date of Dea Month	Day Year	3. Time of Death
Medical Exami		Donis Mo	deline Butler	- 14	h City Toyo or	Location of Deat	November	r 17, 2006 4c. County of Death	1232 hrs
		Shore Highway & Legion		1	Denton	Location of Deat	f1	Caroline	1
Funeral			Sex 7. Age (In yrs Ia	st birthday)	If Under 1 Yea	ar If Under 24Hr	s. 8. Date of Bir	th(MM/DD/YYYY) 9. Bir	thplace (State or
Director		216-16-7878	M 270F 8		Months Day		_	6, 1923 Foreig	nn l
	- }	Usual Residence of Decedent		113.	<u> </u>		nacar	0, 1,,,,	m weg-caree
any		10a State 10b. County	10c. City,	Town or Location	on				10d. Inside City Limits
vlaryland 28a-f show 1 at once.	5	Maryland Carol	ine De	nton					1 Yes 2 No
vlaryla 28a-f 1 at or	Director	10e. Street and Number			10f, Zip Code	_		0g. Citizen of What Cou	
ith the Maryland 23a or 28a-f sho notified at once		9171 Andersontou	on Road		2162	9	1	Inited State	es of Americ
sh with	Funeral	11. Marital Status 1 Never Married 2 X Married	12. Was Decedent Ever in U.S Armed Forces?			spanic Origin? (S n, Mexican, Puerto		14. Race - Amer White, etc.	ican Indian, Black,
or deat	필		1 Yes 2 No		_		,		
15-0036 filed within 72 hours after death with the Maryland Hygiene d other than "natural", or items 23a or 28a-f she the M dical Examiner must be notified at once	۵	3 Widowed 4 Divorce 15. Decedent's Education (Specify	ed If Yes, Give Year or Dates:		Yes 2 X No	tion (Give kind of	work done	Specify: Cauc	
2 hou "nat	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			. DO NOT use re		, and or Edomoso.	in lados, y
thin 7	ם	11 HS Grad		Но	memaker			Home	
5-0(led will lygies other		17. Father's Name (First, Middle, La	st)			18.Mother's Nam	e (First, Middle, f	Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the M dica	8		layton Roe					Gravenor	v-c-se-
ID 2'should and Maric e	٩	19a Informant's Name/Relationship		1.0				nber, City or Town, State	
		Jackie M. Butle 20a. Method of Disposition	s Son	8//8	Bates Re	oad, Den meterv	ton, Max Date	ryland 2162. 20c. Location - City or	
Baltimore, permit Pages I an Department of Hec important: If ite		1 Burial 2 Cremation	3 Removal from State C	rematory or oth nton Ce	er place)			1	
ㄷ 라 의 둘 눈		4 Donation 5 Other Spec			Denton, Mo				
Balti permit Departn Imports injury o	1	Signature of Funeral Service Lice	PMO or	2770	one run	eral Hom	e, P.A.	Denton, Mari	
Physician		23a. Part I. Enter the disease, or co	mplications that caused the death.	Do not enter th	e mode of dying,	such as cardiac	or respiratory arm	est, shock, or heart	Approximate Interval
/Medical		failure. List only one cause or	each line. a Multiple Injuries						Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of	·):					
Mar. 1 "	.	Sequentially list conditions,	b						
	Ē.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	T):					
	Examine	events resulting in death) Last	Due to (or as a consequence of	·):					
3760, ificate be executed gphysician and sthe burial - transit			d						
be ex	n/Medical	UNPENDED	AMENDED						
	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr		al dooth 3	Ectopic pregn	iancy	23d. Date of deliver Month	y Day Year
x 68 h certi	cial	past 12 months?	4 Pregnant at time of dea	oth	ner (Specify)	Laopie pregn	ici icy	World	Jay Tour
Box 687 The death certific the attending pred for use as the	Physicia	1 Yes 2 V No 9 Unkno	9 Unknown		, , ,				
o. hat the ed by letach	by P	Part II. Other significant condition	ns contributing to death but not re	esulting in the u	nderlying cause	given in Part I.		obacco use contribute to	
S, P.(pa pa							s 2 No 3 Prot	
cords law requii	Completed						24a. Was autop	osy prior to d	topsy findings available completion of cause of
Reco The lav icate has	E						1 Yes	rmed? death? 2 No 1 ✔ Ye	es 2 No
tal Recting The certificate ector, page	Be	25. Was case referred to medical examiner?			26.Place	e of Death (Check	only one)		
Physic rthis	5	1 ✓ Yes 2 No		ER/Outpatient				Residence 6 🗸 Othe	r: Scene
n of ding Ph	 E	27. Manner of Death 1 Natural 5 Pendin	28a. Date of Injury (Month, Day, Year) NoV 17, 2006	28b. Time of Ir 1210 hrs	· · I	ıry at Work? Yes 2 ✔ No		how injury occurred auto auto collision	
Sior Attend r death ector: by the	cati	2 ✓ Accident Investig	9	me farm stree			28f Location (Street and Number or Ru	ical Route Number City
Division of Vital Records, P.O. spital or Attending Physician: The law requires that thours after death. Ineral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detain	Certification:	3 Suicide 6 Could r	not be		it, ractory, office i	bunding, etc.	or Town, S		
Hospital		29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge		red at the time d	late and place, an	1		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use as	Medical		ner: On the basis of examination ar						
To To	Me	29b Signature and title of dertifier	and manner stated.		29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)
		241/1XL	1/1/11		O.C.	M.E.		November 18, 20	006
		30. Name and address of person w	no completed cause of death (Item	23a)					
		Susan Hogan MD. As	sistant Medical Examiner	111 Pen	n Street, Bal	timore, MD 2	1201		
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	400	60				
Regist	trar	NUV 2 1 200	Allegar D.	Choracke.	F				

06-08756 Marvin L. Butler Please Type or Print in Black Indelible Ink

Marvin L. Butler		1- For State	tate of Maryla		artment of <i>rtificate of</i>			Menta	al Hy		Reg No	20	ne	. 38	11.
Physicia		Registrar 1. Decedent's Name (First, Midd	lle,Last)						- 12	2. Date of De Month	ath		7	3. Time of Deat	h
Medical Exami	ner		Lewis Bu							Novembe				1416 hrs	
		4a. Facility Name (if not instituti	. 5	umber)		4b. City, To Eastor		ocation of	Death			County of I proline			
· 		Memorial Hospital at 5. Social Security Number	6. Sex	7. Age (In yrs.	lost hirthdov/	If Under		If Under	24Ure	8. Date of B				1bot place (State or	
Funeral Director				7. Age (in yis.		Months		Hours	Min.		`	F	oreian		
3,,,,,,		215-16-8315	1 X M 2 F		86 Yrs					July	2, 75	120	Cour	ntmaryla	ind
any		Usual Residence of Decedent 10a, State 10b, County		10c. City	, Town or Locat	on							1	10d Inside City	Limits
how if		Maryland Ca	voline		Denton									1 Yes 2	No
arylar	Director	10e. Street and Number		<u> </u>	Dercon	10f. Zip (Code				10g. Citize	en of What			
the M a or 2 tified		9171 Andersont	own Road			21	629				Unite	ed St	ate	s of Am	reric
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner myst be notified at once.	Funeral	11. Marital Status	A 1 F	cedent Ever in U						cify Yes or N	0- 1			an Indian, Black	k,
death or ite	Š	1 Never Married 2 N	1 Yes	2 × No		es, specify	Cuban,	iviexican, F	uerto R	ilcan, etc.)		White, 6			
after	à	~	vorced If Yes, Give Yes or Dates:			Yes 2								asian	
hour.	ĘĘ.	15. Decedent's Education (Spi Elementary/Secondary (0-12			16a. Deceden during m	t's Usual C ost of work					16b. Kir	nd of Busir	iess/Ind	lustry	
36 hin 72 than 'dical	ed l	11 HS Grad	Conege (1-4 01 01)	Farme	n/ma	into	nanca	,		Fann	mina/	COLL	nty roa	ıdı
d with	Completed	17. Father's Name (First, Middle	Last)		, a dia	ou na				First, Middle,			Cour	ag nou	
21215-0036 und be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be (Lewis	Butler				- 1	Ge	org.	ia V.	Liste	22			
21 hould hould Me is man		19a. Informant's Name/Relation								ıral Route Nu				Zip Code)	
MD and 2 sho		Jackie M. Butl	ler Soi							n, Mar	~				
ore,		20a. Method of Disposition 1 Burial 2 Crematic	n 3 Removal fr	1	Place of Dispos crematory or oth		e of ceme			Date		ocation - Ci			
Baltimore, permit Pages 1 a Department of He Important: If ite		4 Donation 5 Other 5		De	nton Cen			1	1/2	1/2006	Der	rton,	Ma	ryland	
Ball bermit Depart Impor	1	21 Signature of Funeral Service	11/1/h	11	22. N	ame and A	Address of Fune	of Facility ral h	lome	, P.A.					
Physician		23a Partil. Enter the disease, o	MI No 6	aused the death	Do not enter the	Sour	th S	e c on o	diac or i	neet,	Dento	on, M	ary	<u>land 21</u> Approximate li	
/Medical xaminer		failure. List only one cause Immediate Cause (Final diseas or condition resulting in death)	e on each line. _{e a.} Multiple Inj				-,,-							Between Ons Death	et and
	1	Sequentially list conditions,	b												
1	Examiner	if any, leading to immediate cause. Enter Underlying Cause		a consequence	of):										
_	Ea l	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence	of):								\dashv		
50, te be executed yysician and burial - transit			d												
), be exe sician a	edical	UNPENDED	X AMENDED	#4c, per	ME, g862,	12/16	/06 T	T							
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - trans		IF FEMALE: 23b. Was decedent pregnant in	the 23c. If yes,	outcome of preg	gnancy		3	Ectopic p	rognan	01/		Date of de fonth	-	ıy Yea	or
30x 6876 death certificate e attending phy I for use as the I	Physician/N	past 12 months?	4 Pregr	nant at time of d	ooth -	tal death her (S <i>peci</i>			or egrian	Cy	"	ionin	Da	y Tea	ai
Bo)	hysi	1 Yes 2 No 9 Ur	nknown 9 Unkn	own											
Division of Vital Records, P.O. E and or Attending Physician: The law requires that the drafter death all Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached	Š	Part II. Other significant cond	tions contributing to	o death but not	resulting in the u	inderlying o	cause giv	en in Part	I.					e cause of dea	
rds requi	Completed									24a. Was				psy findings av	
eco he law ite has	Ĕ									perf	ormed?	dea	ath? Yes		No
an: T an: T ertificz tor, pz	ပ္ပုံ	25. Was case referred to medic	al			2		of Death (C	heck or						
Vita hysici this of		examiner? 1 ✔ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DC	OA C	other ₄ I	Nursing	Home 5	Residence	ce 6	Other:		
Division of Vital I the Hospital or Attending Physician: hin 24 hours after death the Funeral Director: After this certifin pletely filled in by the funeral director,	Ę.	27. Manner of Death 1 Natural 5 Per	28a. Date (Month	of Injury h, Day Year) , 2006	28b. Time of I 1210 hrs	njury 28		at Work?		8d Describe Priver auto					
Siol Attend death death cector:	cati	E FEI	estigation			t fastss.		es 2 V N		Of Leastion	(Chanal and	d Marshau	D	I Davida Niverba	or City
Divi	ij	det	ald not be		nome, farm, stree ad / Highway		onice bu	ilaing, etc.		or Town, hore Highw	State)			Route Numbe	er, City
lospit 4 hour uners	ညီ	29a. Certifier	Physician; To the be				time date	e and place							
the H thin 2- the F nplete	Medical	(Check only	aminer: On the basis	of examination	_										
Division of Vital Reco To the Hospital or Attending Physician: The law within 24 hours after death To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.s.	Me	29b. Signature and title of certif	and manner s	stated		29c.	License	number			29d. Da	ate signed	(Monti	h, Day, Year)	\neg
		XXV/e	JUN 1	101			O.C.IV	1.E.			Nove	mber 18	3, 200	16	
	ŀ	30. Name and address of perso	n who completed cau	se of death (Iter	m 23a)										
		Susan Hogan MD.	Assistant Medic			n Street	, Baltir	nore, M	D 212	01					
St	ate	31. Date filed (Month, Day Year) 22. R	egistrar's Signat	ture	0 .									

06-08900 Abigail Cain

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

bigaii caiii			eate of Death	Reg. N	. 2006 2011
Physici	an/	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day November 22	Year 0300 hrs
Medical Exami		Abigail Faith Cain 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		, 2006 USOUTHS 4c. County of Death
		Shady Grove Adventist Hospital	Rockville		Montgomery
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	rthday) If Under 1 Year If Under 24Hr Months Days Hours Mi		M/DD/YYYY) 9. Birthplace (State or Foreign
Director		N/A 1 M 2 XF	Yrs. 5	Nov. 17,	2006 Country) MD
ru)	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Towr	n or Location		10d. Inside City Limits
Maryland 28a-f show any <u>d at once.</u>	٦	MD Montgomery (Gaithersburg		1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number	10f. Zip Code		Citizen of What Country?
ith the? 23a or notifie		584 Orchard Ridge Drive, # 100 11. Marital Status 12. Was Decedent Ever in U. S.	20878 13. Was Decedent of Hispanic Origin? (§		United States 14. Race - American Indian, Black,
5-0036 ed within 72 hours after death with the Maryland tygiene other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Married 12. Was Decedent Even II 0.5. 1 X Never Married 2 Married 12. Was Decedent Even II 0.5. 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puert		White, etc.
after d al", or	by Fi	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:		Specify: White
hours natur		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use re		o. Kind of Business/Industry
5-0036 led within 72 hours Hygiene other than "natur the Medical Exam	ompleted	O Soliege (14 of 51)	N/A		N/A
5-003 iled withii Hygiene I other th	O	17. Father's Name (First, Middle, Last)	18.Mother's Nam	ne (First, Middle, Maid	en Surname)
be f be f rked	o Be	Jason Gary Cain 19a Informant's Name/Relationship (Type, Print) 19	Mo b. Mailing Address (Street and Number or	nica Eliza	abeth Wiermanski
AD 2 2 shou h and h 27 is n matic	Ė		584 Orchard Ridge Dr		
imore, MC Pages 1 and 2 s nent of Health an ant: If item 27		20a Method of Disposition 20b. Place	of Disposition (Name of cemetery,		c. Location - City or Town, State
Baltimore, MD 21 oemit Pages I and 2 should Department of Health and Me Important: If item 27 is ma njury or other traumatic ev	D	4 Donation 5 Other Specify: Calva	ary Cemetery 27	, 2006	Winnebago, IL
Baltimo permit Page Department o Important: injury or oth		21. Signature of Funeral Service Library			al Home, 10 East
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do r	Deer Park Drive, not enter the mode of dying, such as cardiac		shock, or heart Approximate Interval
/Medical Examiner		failure. Listonly one cause on each line. Immediate Cause (Final disease a. Probable metabolic	disorder		Between Onset and Death
/		or condition resulting in death) Due to (or as a consequence of):			
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last vents resulting in death) Last			
xecuted n and l - transit		d			
50, te be exerging ysician	/Medical		erME, g864, 2/8/07 TT	-	
8760, rtificate be ing physici as the buri	M/us	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth	y 2 Fetal death 3 Ectopic pregr		23d. Date of delivery Month Day Year
Box 68's death certificate attendings	sician		5 Other (Specify)	- 1	
D. B. r the de by the ached f	F.	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
, P.O. res that the signed by be detach	d by			1 Yes 2	No 3 Probably 4 Unknown
ords, w requir	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Reco The law cate has	mo;			performed 1 Yes 2	
tal Rec cian: The certificate ector, page	Bec	25. Was case referred to medical examiner?	26 Place of Death (Chec Outpatient 3 DOA Other Nurs		
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ra after death. an Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	욘	1 V Yes 2 No Pripatient 2 ENA 27. Manner of Death 28a Date of Injury 28b	Outpatient 3 DOA Outlet Nurs Time of Injury 28c. Injury at Work?	ing Home 5 Res	idence 6 Other:
ion C trending leath. tor: Af	Certification:	1 X Natural 5 Pending (Month, Day,Year)	1 Yes 2 No		
Divisi pital or Att ours after de teral Direct filled in by	ifica	3 Suicide 6 Could not be	farm, street, factory, office building, etc.	28f. Location (Street or Town, State	et and Number or Rural Route Number, City
Dj ospital hours a meral y filled		4 Homicide determined (Specify) 29a. Certifier A Cartic Inc. Physicians To the best of my knowledge determined			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or			
To wit	Mec	and manner stated. 29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
		Jashe Geefris	O.C.M.E.	N	ovember 23, 2006
		30. Name and address of person who completed cause of death (Item 23a)		MD 21201	
	tate	Tasha Greenberg MD. Assistant Medical Examiner 31. Date filed (Markin Pay, Year) 2000 32. Fegistrar's Signature.		ער בובעו	
Regis	tate trar	INCLV Z. (/DUDI Rea /K	Sparle		

06-08958

Ste

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even Victor Cor	1	tt State of Maryland / Department of H 1- For State Certificate of D Registrar		Reg. No.	2006 38119
Physicia	n/	Decedent's Name (First, Middle,Last)		te of Death inth Day vember 24, 2	3. Time of Death
ledical Examin		Steven Victor Cornett 4a. Facility Name (if not institution, give street and number) 4b. (institution)	City, Town, or Location of Death		County of Death
			rederick	F	rederick
Funeral Director		o. docidi docarity removi	Months Days Hours Min.	ine 21,	DD/YYYY) 9 Birthplace (State or Foreign Country) 0h1o
ò		Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location			10d Inside City Limits
ow any		Tod, diale			1 X Yes 2 No
Maryland 28a-f show 1 at once.		Maryland Frederick Frederick 10e. Street and Number 10	Of Zip Code	10g Citi	zen of What Country?
ith the Ma 23a or 28 potified	Dire	412-B West South Street 2	1701	USA	
h with	la l	11. Marital Status 12. Was Decedent Ever in U.S 13. Was D	ecedent of Hispanic Origin? (Specify Specify Specify Cuban, Mexican, Puerto Rican,		14. Race - American Indian, Black, White, etc.
er deat	핆	X Never Married 2 Married 1 Yes 2 X No	es $2[\overline{\mathbf{X}}]$ No specify:		Specify: White
urs afte tural"	함	or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's I	Usual Occupation (Give kind of work do		Kind of Business/Industry
6 72 hor un "na cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use retired)		
003(within giene her (ha	el el	2 Salesma 17. Father's Name (First, Middle, Last)	n 18.Mother's Name (First,		cail - Electronics Surname)
21215-0036 Muld be filed within 72 hours after Mental Hygiene nnarked other than "natural", c e event, the Medical Examiner	Bec	Clyde Victor Cornett	Phyllis Jean	n Beatty	7
		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	ddress (Street and Number or Rural R	Route Number, C	ity or Town, State, Zip Code)
MC alth are alth are alth are are are are are are are are are are	-	Clyde V. Cornett, father 429 Enx 20a. Method of Disposition 20b. Place of Disposition	ing Avenue, Dayton (Name of cemetery, Date	n, Ohio	45449 Location - City or Town, State
Baltimore, MD sernit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		1 Burial 2 X Cremation 3 Removal from State crematory or other	place)	2006 5mi	thsburg, Maryland
Iltim	-				sford Funeral Home
Dep Dep Inju		Ryan M Berger (per DVR) M00999 106	East Church Stree	t, Frede	erick, MD 21701
Physician /Medical		23a Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line		iratory arrest, sho	ock, or heart Approximate Interval Between Onset and Death
Examiner	1	Immediate Cause (Final disease or condition resulting in death) a Narcotic (Morphine) intoxio	cation		Dount
F		Sequentially list conditions, b			
	iner	If any, leading to immediate Due to (or as a consequence of):			
si. d	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		<u>. </u>	
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death for the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	cal	X UNPENDED X AMENDED #24a-b, perME, 986	3, 1/5/07 TT perME, g862, 12/21/06		
60, ate be		#21,23a,27,28a-1,	perME. g862. 12/21/06	23	d Date of delivery
6876 certifica nding ph	jan/	23b Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal 4 Pregnant at time of death 5 Other	death 3 Ectopic pregnancy		Month Day Year
Box e death ce the attented for us	ysic	1 Yes 2 No 9 Unknown 9 Unknown			
P.O. B res that the dissigned by the be detached	by Pr	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I		use contribute to the cause of death? No 3 Probably 4 Unknown
Division of Vital Records, P.O. teal or Attending Physician: The law requires that the stafe clean al Director: After this certificate has been signed by led in by the fumeral director, page 2 should be detach	ted t			24a. Was an	24b. Were autopsy findings available
cords law requii has been s	Completed			autopsy performed?	prior to completion of cause of death?
tal Rection: The certificate			26.Place of Death (Check only o	H V Yes 2[X]N	No 1 Yes 2 X No
Vital hysician: this certif	o Be	examiner? Hospital: Innation: 3 FR/Outpetient 1	Other		ence 6 🗸 Other, Scene
n of V	n: To		", , , _	Describe how in	jury occurred
Sion ttendi death ctor: y the f	atio	Natural 5 Pending Fnd 11/24/2006 Fnd 3:10	Jani _	known	and Number or Rural Route Number, City
Division pital or At ours after deral Direct filled in by	Certification:	3 Suicide 6 XCould not be determined (Specify) Found: residence	Apt.	or Town, State)	412-B West South St.
Hospit 24 hour Funer: tely fill			d at the time, date and place, and due t	to the cause(s) a	nd manner as started.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated			
- > - >	Š	29b. Signature and title of certifier	29c. License number O.C.M.E.		Date signed (Month, Day, Year) vember 28, 2006
		20 New and oldress of some who combined even of death (flow 22a)	J.J.Wi.E.	1,40	
		30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 21201		
	tate		9	•	
Regis	trar	NOV 3 0 2005 Jakes 25.			

			State of Maryland / Department of Health and N	-	_	38120
_			Registrar Certificate of Death	2. Date of Death	g. No.	
	Physici	an	1. Decedent's Name (First, Middle, Last)	Month	Day Year	3. Time of Death
	/Medic		Lloyd West Dennis Jr.	11/	13/2006 4c. County of Death	1832 ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death			
			Atlantic General Hospital Berlin 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Worcester	- place (State or Foreign ntry)
	Funeral Director		212-40-9019 1X M 2 F 62 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 02/16/1	Year) Cou	MD
ک =			Usual Residence of Decedent	02,10,1		
00	how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
200	a-f s	Director	MD Worcester Berlin			1 ☐ Yes X (X)No
00	ith th	Olre	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?
00	23a	ral	11747 Showell School Road 21811		USA	
1	ar de s	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
36	s afte	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No Specify: Year or Dates:		Specify: Whit	ie
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or Items 23a or 28a-f show ent, the Medical Exercit et court be notified al	ed t	15. Decedent's Education 16a Decedent's Usual Occupation	1	6b. Kind of Business/Ir	dustry
0 5	ıln 72 n "ne	plet	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ring		
Ω 213	yiene r the	Completed	Elementary/Secondary (0-12) College (1-4or5+) 10 Truck Driver		Trucking	
کے کے	e filed Il Hygi other vent, Il	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, M	laiden Sumame)	
<u>/a</u>	Venta Venta rrked	ဥ	Lloyd W. Dennis Sr. Reba Ma	e Britti	ngham	
arphi Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heath and Mental Hygiene. It heath and Sa or 28e-f show tem 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Modical Exercities count be notified at		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run 19t. Mailing Address (Street and Number or Run 11747 Showell School R			
7 0	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other tra once.	1 10			Oc. Location - City or T	
119	Page ment ent: b		`4X∑Donation 5 □Other (Specify) Anatomy Gifts Registry 11/			
lalt	srmit. spart poort yy inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bu	TO A PRODUCE THE PARTY OF THE P		
9 B	20529		Machillere J. Daffette: 108 William Street		_	
9			A. Part1. Enter he disease, or multiations that cluse the death. Di not enter the mode of wing, such as cardiac shock, or hear failure. List only one cause on each list.	or repiratory arre	st,	Approximate Interval Between Onset and Death
Ö	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. CRONARY HTTOYU	disc	ase	
1	Examiner		Due to (or as a consequence of)	dise	aso	
30		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			-
2	te be executed ysician and e burial-transit	Examiner	that initiated events			
760,	e exe ian a urial-		resulting in death) Last Oue to (orbit a consequence of):			
× 876	# × 6	llcal	Morethand			
0 × 68	eath certificate attending phy I for use as the	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		02d Date of deliv	
S/O Box	attend attend for us	lan	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delive Month	Day Year
310	be def	Physician/Med	1 Yes 2 No 9 Unknown			
P.O. P.O.	that the		Part II. Other significant conditions contributing to weath but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	he cause of death?
$\frac{1}{2}$ ords	quires n sign ld be	d by	TODGCCO Abuse	1 X Ye	s 2□No 3□Pro	bably 4 Unknown
_ ~ 0	w requir s been s should	lete		24a. Was ar	24b. Were aut	opsy findings available
2 - 5	rhe lav te has age 2	Completed		autopsy perform 1 Tes 2	ed? death?	impletion of cause of 2□ No
Vital Vital		e e		th (Check only one		
0 Y	ysicl is ce direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hospital:	ome 5 Reside	nce 6 Other (Speci	fy)
Lloy n of Vi	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury Work?	28d. Describe ho	w injury occurred	
Sio	eath. or: A	catio	2 Accident investigation M 1 Yes 2 No	00/ 1		-/ Courts Mountain
4 Division	after d Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	reet and Number or Rur , State)	ai Houle Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific; completely filled in by the funeral director,	edical C	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	and due to the ca rred at the time, da	use(s) and manner as ate and place, and due	stated. o the cause(s)
	To the P within 2 To the F complet	Med	onel and manner stated. 29b. tiggature and title of cartifier 29c. License number	29	d. Date signed (Month)	Day, Year)
	FIFO		THINGS has bollow MO MOOSS 976		11/14/	06
	_		30. Name and a lea of person who completed cause of death (Item 23a) (Type, Print)		Q	1. 40
آع	d		LOCYCAN VOORHEES 314 FRANKLI. 31. Date filed (Month, Day, Year) 32. Projistra's Signature	N FIV	E DEN	1:2 , MJ
- 1	St Regist	ate trar	NOV 1 5 2006 Rever & Species			

Amjad Mohdmin Dallal

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 38121

		1- For State Registrar			C	Certifica	ate of	Deat	h			R	eg. No.	JUC) 001	i 1
Physicia	an/	1. Decedent's Name		Month Day Year										3. Time of Death		
ledical Exami	ner	Amjad 4a. Facility Name (if r		Iohdamir		alla.		o City 1	Town, or Lo	ocation o		Novembe	r 22, 2006 4c. County		1330 hrs	
1		9622 Marstor	n Lane					Mont	gomery	Village	•		Montgo	mery		
Funeral Director		5. Social Security Nu 307-82-7		6. Sex	7. Age (In y 4 6		hday) Y rs.	Month	er 1 Year Days	If Under Hours	Min.		/1960		thplace (State or In Kuwait untry)	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygins and Mental Hygins and The marked other than "natural", or items 13a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Md. 10e. Street and Number 19622 Marx 11. Marital Status 1 Never Married 3 Widowed 15. Decedent's Edu Elementary/Secon 17. Father's Name (FAmin 19a. Informant's Name Robin R. 20a. Method of Dispon 1 X Burial 2 4 Donation 5 21. Signature of Fund	Ob. County Montgo Berroston d 2 X Mar 4 Divo Jucation (Special Address (0-12) First, Middle, L Dal De/Relationsh Dal Osition Cremation Other & General Service L	Lane 12. Was December 12. Was December 12. Was December 13. Yes 14. Yes 15. Yes 1	cedent Ever is orces? 2 X N ar ide completed 1-4 or 5+)	191 190 1900b. Place of cremat Mary	13. Was If Ye 1 Decedent' during mo i vil Decedent' corrections or other land 22. Na 4 1	Decedes, special Yes 2 Susual St of wo Address Mail Indian (Natural Place In Natural In Inc.)	ent of Hisparity Cuban, In Manager 18 Control of the Control of th	anic Orig Mexican, specify: on (Give k DO NOT on neer Awa and Num n La etery, nal	in? (Spec Puerto Ri tind of wor use retired tes ber or Run ine 1 11/2 Un: St.	rk done First, Middle, Pal Route Nur Montga Date 25/06 IVersa , N.W.	Specify. Specify. Engi Maiden Surnam allal nber, City or To Omery 20c. Location Laure al Mor Washi	e - Amerite, etc. Wh: usiness/li nee: Vi: - City or l, M tuan ngt c	can Indian, Black, Lte Industry Ling Zip Code) 208 Llage, Md Town, State	No 886
Physician /Medical Examiner													Approximate Inte Between Onset a Death			
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d Sit	Examiner	(Disease or injury the events resulting in de	at initiated	c. Due to (or as	a consequen	ce of):									1	
760, cate be execute physician and the burial - tran	n/Medical E	X UNPENDED		d AMENDED	#23a.P	TT.27.	28a-f	er	MF. 08	 3631	/5/07	TT				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	sicia	IF FEMALE: 23b. Was decedent p past 12 months?	,	1 Live	outcome of pointh and at time of a	pregnancy	2 Feta		3	_	pregnanc		23d. Date of Month		r Day Year	
, P.O. E ires that the d signed by the	by Phy	Part II. Other signifi		•	to death but r	not resultin	g in the ur	nderlying	g cause giv	en in Pa	rt I.		obacco use con	process	the cause of death?	
rds, Frequires	Completed		aine use								_	24a. Was	an 24b.	Were au	topsy findings availa	able
of Vital Records, ng Physician: The law require the this certificate has been si neral director, page 2 should be	Somp						_						rmed?	death?		
tal Rection: The certificate ector, page	Be (25. Was case referre examiner?	ed to medical	Hospital:					26.Place c	of Death (other					_	
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Division ral or Attendir rs after death. al Director: Aled in by the fu	cati	2 Accident	Invest	tigation Ind I	1/22/200 ce of Injury -		1:26			Λ		unknown 8f. Location (Street and Num	per or Ru	ral Route Number. (City
Divi	Certification:	3 Suicide 4 Homicide	6 XCould	not be mined (Specify			,					or Town, S Monteome	State) 9622 erv Villa	Mars De. M	ral Route Number, (Con Lane)	
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the i	Medical C	29a Certifier	Certifying Ph Medical Exan	ysician: To the be	est of my know of examinati	vledge, de	ath occurr	ed at the	e time, date y opinion, e	e and pla death occ	ce, and de	ue to the cau	se(s) and manne	er as star	ted.	
To the Cor	Me	29b. Signature and t	itle of certifier	and manner	otateu		_	29	c. License						nth, Day, Year)	
		30 Name and addre	- 54.5	who completed car	use of death (Item 23a)			O.C.M	I.E.			Novembe	r 23, 20)U6 	
		Margarita Ko	rell MD.	Assistant Me	edical Exa	miner	111 Pe	enn St	reet, Ba	ltimore	, MD 21	1201				
S Regis	tate		Oay Year)	7 2006 ^{32. R}	egistrar's Sig	nature	An	1000	0							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 0619 M Edith Mae Du 4a. Facility Name (If not institution, give street and number) 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbi Wi Comico Resinch Medicil
6. Sex 7. Age (In vis. II 5. Social Security Number 2/3-22-6020 If Under 1 Year If Under 24 Hrs.
Months Days Hours 7. Age (In yrs. last birthday)
Yrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 K 9-25 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show 10c, City, Town or Location 10d. Inside City Limits 10a. State Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the M-dical Examiner must be notified at Fruitland 1XYes 2 □ No MD WI Comico Director 10g. Citizen of What Country? 10e. Street and Number U.S.A. 405 N. DiVisionst 21826 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 NNo If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 No þ 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 501156m College (1-4or 5+) Elementary/Secondary (0-12) L.P.N. Nursin 12 th grale 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Pages 1 and 2 should be nent of Health and Mental usephine Jesse JAMES Wright Viola 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Dutton Harding 410 South BIVD Salis burg, mad 21801

Date 200 Location - City or Town, State 200. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 DBurial 2 □ Cremation 3 □ Removal from State Flawer Hill Ceneters 11-18-06 Ede 22. Name and Address Facility Bennie Smith Funeral Home 417 W. BAbella St Salisbury m Eden, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lic 23a. Part1. Einer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Just only one cause on each line. Salisbury md 21801 Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Lohrs /Medical Examiner Due to (or a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Diabetic Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month in the past 12 months? 1☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ bhknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0) me 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1920

State Registrar 31. Date filed (M

1 5 2006

DHMH 17 Rev 1/2001

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32. Begistrar's Signature

	•	For State Ragistrar		State	of Mary			rtment o <i>tificate</i>			and Me	ental Hy	gien e Rog. No.	006	4	381	23	
		1. Decedent's Nam	e (First, Middle,	Last)						,		2. Date of De	ath	Van		3. Time of	f Death	_
Physicia /Medic		Robert		R.		Elder	II	I .				Novemb	er 3	2006		7:51	а м	
Examin		4a. Facility Name (If not institution,	give street and	number)			4b. City, To	wn, or Lo	ocation o	of Death		4c.	County of De	ath			
			all Lane						apo1					Anne				
Funeral		5. Social Security N		5. Sex 15√1 M 2 □ F		yrs. last bir	thday)_ Yrs.	If Under 1 \ Months D		f Under Hours	Min	8. Date of Bir (Month, Da	th y, Year)		Countr		_	1
Director		Usual Residence o		Λ		59	113.					June 1	194	/ Ma	ISSA	chus	etts	_
land ow	Ì	10a. State	10b. County		10	c. City, Town	n or Loc	ation							100	d. Inside C	ity Limits	_
Mary -f eh	ō	MD	Anne	Arunde]	L	Anna	pol:	is								1 🗌 Yes	2 X No	
r 288	Director	10e. Street and Nu	mber					10f. Zip Co	ode				10g. Citi	zen of What	Countr	y?		_
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deat	Funeral	11. Marital Status		12. Was D	ecedent Ever Forces?	r in U.S.	13. W	as Deceden	nt of Hispa	anic Ori	gin? (Spec	city Yes or No	-	14. Race - A	nerica			-
or its			ried 2∐ Marrie		s 2 No			Yes, specify □ Yes 2【X	_	Specify:	i, rueito n	ilcari, etc.)		Black, W		nite		
iner:	d by	3 Widowed	4XX ivorced		r Dates: V	ietnam	n '		1140	opecny.				Specify:	W 1	11.00		_
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d be said	00		R. Elde:									Weston		our amo,				
inc, intelly latter A. I.E. I.S. 1000. s. 1 and 2 should be filed within 72 hours after death with the Maryland it health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinatinust be notified at	ဥ	19a. Informant's N				19b	Mailing	Address (S				Route Numb		r Town. State	a. Zio C	Code)		-
ING 2 ST In Trau			W. Eld		ner)	1.1						, Latr						
ges 1 and for Health if item 27 or other tr		20a. Method of Dis	position		2	20b. Place of	Dispos	ition (Name	of		Da			cation - City		-		
Page ento y or			Cremation : 5 ☐ Other (Spe			Metro	· .	atory`or othe matory		i	11-7-	-2006	Ra 1	timore	. N	ΔD		
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		23a. Part 1. Enter	the disease, or cart failure. List o	omplications tha	at caused the	death. Do								,	1	Approxima Interval Be		
Physician		Immediate Cause	(Final	144	FTAS	40	7/	1 12	17-	_ (AN	200			X	Onset and	Death	9
/Medical		resulting in death)		a. Due	to (or as a co	nsequence	of):		100		1310	W /		-	7	1070	ביחיב	>
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the d	Physician/M	1 ☐ Yes 2 9 ☐ Unknown			known	e or death	30	Other (speci	"y)									
that thed by deta		Part II. Other signi	ficant condition	s contributing to	death but no	ot resulting in	n the un-	derlying cau:	se given i	in Part I.		23e. Did 1	obacco u	se contribute	to the	cause of	death?	_
requires t	d by											·×	Yes 2	□No 3□	Proba	bly 4 🗆	Unknown	
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Physicien: The law requires that the death certificate has been signed by the attending ral director, page 2 should be detached for use as	0	25. Was case refe	rred to medical						21	6 Place	of Death	1 ☐ Yes (Check only	2/No	1 D Y	es 4	No		
ysici ysici is cer direc	0 8	examiner? 1 ☐ Yes 2 ☐	(No	Hospital: 1	☐ Inpatient	2 ☐ ER/Ou	itpatient	3□ DOA	Other:		rsing Hom			3 □Other (S	pecify)			
lerth beral	n: T	27. Manner of Sa		/8.4	ite of Injury Ionth, Day Ye		Time of njury		: Injury at Work?			8d. Describe						
tending leath. for: Afte the func	atic	1 Natural 2 Accident	5 Pending investiga	ition			,,	М		s 2 🗆	No							
r Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	200. PR	ace of Injury - ilding, etc. (S	- At home, fa	ırm, stre	et, factory, c	office		2	8f. Location (City or To			Rural	Route Nur	mber,	
re in a start of the start of t			,															
Hosp 24 hou Fund fely fi	edical	29a Certifier (Check only one)	2 Medical E	Physician: To xaminer: On the	e basis of exa	amination an	a daath d/or invi	estigation, in	the tima: my opini	date an ion, dea	d place at th occurre	nd due to the d at the time,	date and	and manner place, and o	as eta tue to t	ted. the cause((s)	
To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Med	29b. Signature and	d title of certifier	anu m	anner stated			29c, L	icense n	number			29d. Da	e signept (Ma	onth, D	ay, Year)		
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		30. Name and add	ress of berson w	no completed	ause of death	(Item-23a)	(Type F	Print)			,		"	1031	~ ~	0		-
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Sta	te	31. Date filed (Mo		3000	Registrar's	Signature		الدو الا) J	-1-	- 1-1		111		-4-5			_
Registr			NOV 0 9	2006	BOW.	Jak.	-	Mary .										

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Charles Fisher a M 13, Fitzmaurice November 2006 1:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3307 Wake Drive Kensington Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** Days 1XT M 2∏ F Director 161-28-1920 75 Nov. 7, 1931 Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location a or 28a-f show be notified at 10a State 10b. County 10d. Inside City Limits 1 ☐Yes 🌪 ☐ No Director Maryland Montgomery Kensington 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code and 2 should be filed within 72 hours after death with tealth and Mental Hygiene. ns 23a c must b 3307 Wake Drive 20895 USA Funeral Items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 No if Yes, Give Year or Dates 1951-53 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or Item Black, White, etc 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√€ No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Private & Public 鼎 5+ Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Charles E. Fisher ပ Ruth Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai Eden E. Fisher Durbin/Daughter 3307 Wake Drive, Kensington, Maryland 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 14, Nov. Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2006 Alexandria, Virginia 21. Signatur of Puneral Service Licensee Francis Address of Facilities Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or correlications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) a Liver Failure ess than /Medical Due to (or as a consequence of): month Examiner b. Metastatic Colorectal Cancer more than 3 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner years physician and s the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 in the past 12 months? Month Year Dav 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) ☐Yes 2☐No P.0. detached the 9 Unknown signed by 1 3 be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, **\$** 1 Yes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 has autopsy performed' certificate 1 Yes 2 No Physician; To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division (Month, Day Year) 5 ☐ Pending investigation **x**√x Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D35996 November 13, 2006 9+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda M. Burrell, M.D. 2730 University Blvd., #400, Wheaton, MD 20902 31. Date filed (Month, Day, Year) State Registrar 5

DHMH 17 Rev 1/2001

		1	1 - For State Registrar		State of Ma	arylanc		artment of <i>rtificate c</i>				iene	006	38125	5
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	Examin				re street and number)			4b. City, Town	n, or Location	of Death		4c.	County of Dea	th	
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	Funeral		5. Social Security N		Sex 7. Age 1 □ M 2 🔀 F		st birthday)	If Under 1 Ye Months Da		r 24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Bir	thplace (State or Forei	ign
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	ms 2	Funeral	11. Marital Status		12. Was Decedent 8	Ever in U.S	3. 13.	Was Decedent of Yes, specify C	of Hispanic O	rigin? (Spe	cify Yes or No-		4. Race - Am		_
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2-0036	urat',	d by	3 Widowed		Year or Dates:			103 2241	10 Specify				Specify:	White	
<u> </u>	nati	Completed	(Spec	 Decedent's E ify only highest gr 	ducation ade completed)		16a. Deced	dent's Usual Oc kind of work do DO NOT use re	cupation ne during mo	st of workin	ng	16b. Kir	nd of Business	/Industry	
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N D	e filed with Hygiene other the	Ö	17. Father's Name (ukn		110	Juse Rec	1	ner's Name	(First, Middle,			ukn	
<u>a</u>	id be ental ked c	To B													
3	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Heelth and Mental Hygiene. If Item 27 is marked other than "naturel", or items 23a or 28a-1 show or other traumatic event, the Madical Examinating and itself and itself and itself.	-	19a. Informant's Na	ıme/Relationship	Type, Print)		19b. Mailir	ng Address (Str	eet and Numb	ber or Rura	Route Numbe	r, City or	Town, State,	Zip Code)	
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e G	of He of He of He of he		20a. Method of Disp		7.0	20b. Pla	ace of Dispo	sition (Name of natory or other		D	ate	20c. Lo	cation - City or	Town, State	
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			23a. Part1. Enter the shock, or hear	ne disease, or con rt failure. List only	nplications that caused one cause on each lin	the death.	. Do not ent	er the mode of	dying, such as	s cardiac o	respiratory ari	est,		Approximate Interval Between	
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ם מ	death	slcia	in the past 12 1 Tes 2		4 Pregnant at			Ectopic pregna Other (specify					Month	Day Year	
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s S	w requires thet the de been signed by the s should be detached	by	Part II. Other signif	icant conditions	contributing to death be	ut not resul	lting in the u	nderlying cause	given in Part	I.	Tri .			o the cause of death?	
itai Hecords,	equir	ted									1 U Y	es 2[No 3∏P	robably 4 Honknov	МΠ
Ö	law a 2 st	ompieted									24a. Was a autop	SV	24b. Were a prior to	utopsy findings availat completion of cause of	ble of
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	ding in After funer	ertification;	1 Inatural	5 Pending	(Month, Day	Year)	Injury		njuryal Work? □ Yes 2 □		.8d. Describe h	ow injury	Occurred		
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É	effer Dire	erti	4 🗋 Homicide	determined	building, etc	: (Specify))	M			City or Tow				
	To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	calc	29a. Certifier (Check only	1 Cartifying P	hysician: To the best of	of my know	vledge, death	occurred at th	e time, date a	ind place, a	ind due to the o	ause(s)	and manner a	s stated.	
	in 24 in 24 the Fi	edicai	one)	2 Madical Exa	minar: On the basis of and manner sta	examination ited.	on and/or in	vestigation, in n	ny opinion, de	ath occurre	ed at the time, o	ate and	place, and du	e to the cause(s)	
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			For State Registrar	State of Man	yland / De _l <i>C</i> e	partment of F ertificate of	lealth an <i>Death</i>		giene2 () (06 38126
			1. Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death
	Physici		Sandra	Nast		Far	~	No vember		Year 2233 M
1	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of D		4c. County of	
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	Funeral		5. Social Security Number 6. Se	x 7. Age (/	n yrs. last birthda	y) Trunder 1 Year		Hrs. 8. Date of Birtl		9. Birthplace (State or Foreign
	Director		220-42-3484	DM 24□F 6	2 Yrs.	Months Days	Hours N	Hrs. 8. Date of Birtl (Month, Day NOV • 2 •	1944	Washington
			Usual Residence of Decedent							
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	Man	ō	Md. Montgom	erv	Chevy	Chase				1 K Yes 2 □ No
	the 28s	Director	10e. Street and Number		01.01	10f. Zip Code			10g. Citizen of W	/hat Country?
	with	٥	6609 Kennedy Dri	ve		2081	.5		USA	,
	be filed within 72 hours after deeth with the Maryland Hydiene. Hydiene Hydiene of other than "natural", or iteme 23a or 28a-f ehow of other than "natural", or iteme 23a or 28a-f ehow event, the Medical Examinar must be notified at	Funerai	11. Marital Status	12. Was Decedent Eve	rin II S 1:			2 (Specify Yes or No-		- American Indian,
	iten d	E	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 2 No		If Yes, specify Cub	an, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	Black	k, White, etc.
36	rs af	by	3 ☐ Widowed 4 ♣ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify:	White
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Maryland	d 2 should th and Mer 7 is marke traumatic	1 3	19a. Informant's Name/Relationship (T) Amanda Farr/Daug			-		r Rural Route Numbe		
4	permit. Pages 1 and 2 Department of Health Important: If item 27 I any injury or other tra once.		. 9				Lane, I	Bethesda, 1		
Baltimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ I		cemetery, c	position (Name of rematory or other pla	ce)	Date	20c. Location - 0	City or Town, State
Ē.	Pag ment: ant: ury c		4 ☐ Donation 5 ☐ Other (Specify,		Columbia	Gardens	Cem No	ov.17,06	Arlingt	on, Va.
a H	port port y in		21. Signature of Funeral Service Licens	(ae) / //		22. Name and Addre	ess of Facility I	eVol Fune	ral Home	
m	205 5 8		KHEN IT X	tll						on, DC 20007
			23a. Part1. Enter the disease, or comp	lications that caused the						Approximate Interval Between
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	/Medical		disease or condition resulting in death)	a. Ischen Due to (or as a c		owel				
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	uted insit	듵	if any, leading to mine diate cause. Enter Underlying Cause (Disease or injury							
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8760,	The law requires that the death certificate be executed ite has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical E								
687	icate phy: s the	ig ig		0						
×	eath certific attending p for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome of p	pregnancy				22d Date	e of delivery
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o ·	t the de by the	ysic	1 □ Yes 2 154No 9 □ Unknown	9 Unknown	o or dealit	Cities (specify) _				
P.0	that the od by detac		Part II. Other significant conditions co	ntribution to death but r	ot resulting in the	underlying cause on	ven in Part I	23e Did to	bacco use contri	ibute to the cause of death?
of Vital Records,	signe signe 1 be	þ				and my my data of gr	VOIT II 1 V GIV 1.			3 ☐ Probably 4 ☑ Unknown
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ec	law lasb	Completed	Peripheral Va	Scular D) seas-	د		24a. Was a autop	SV DI	Vere autopsy findings available rior to completion of cause of
<u> </u>	The I	Š								eath? ☐ Yes 2☐ No
<u> </u>	ician: Th certificate rector, pag	Be (25. Was case referred to medical				26. Place of	Death Check only or	ne)	
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0	g Ph erth eral		27. Manner of Death	28a. Date of Injury	28b. Time				ow injury occurre	
9	nding I th: : After s funer	유	1 ☑ Natural 5 ☐ Pending investigation	(Month, Day Y	ear) Injur		rk?]Yes 2∐No			
Division	Attending in death.	flea	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury building, etc. (- At home, farm,	street, factory, office		28f. Location (S	treet and Numbe	er or Rural Route Number,
ă	tel or Attendii s after death. al Director: A ed in by the fu	Certification:	4 Homicide	building, etc. (Specify)	•		City or Tow	m, State)	
	epite lours neral filler		29a. Certifier Certifying Phy	rsician: To the best of n	ny knowledae. de	ath occurred at the ti	me, date and n	place, and due to the	ause(s) and man	oner as stated
	24 h 24 h Fui etely	Medical	(Check only 2 Medical Examone)	iner: On the basis of ex and manner stated	amınation and/or	investigation, in my	opinion, death o	occurred at the time, o	date and place, a	indidue to the cause(s)
	To the Hoepitel or A within 24 hours after To the Funeral Dire completely filled in by	Me	29b. Signature and title of certifier			29c. Licens	se number	1	29d. Date signed	(Month, Day, Year)
	1/		Dani - Alina	e MD		000	- 00	0 1	J 0210 mak -	er 11,2006
	10		30 Name and address		h (ltom 23c) C	-			C 4 C 18194	.,,
			30. Name and address of person who c				1 D ~	الم الم	10 21	297-9106
			31. Date filed (Month, Day, Year)	32. Pe gistrar's		e stree	1, 100	(Ill more)	u	201- 1100
	Sta Registi			006	. K. A	colle				

Division or Vital Records, P.O. Box 68760 Attending Physician:

Certification: To Funeral Director: After tely filled in by the furera 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or A within 24 hours after or To the Funeral Direction 4 ☐ Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 D 42452 November 13, 2006 omple cause of death (Item 23a) (Type, Print) 30. Name and address of person w M.D., 18111 Prince Philip Drive, Olney, Maryland 20832 Dr. Chitra Rajagopal, 31. Date filed (Month, Day, Year) Registrar's Signature State 15 2006 NOA Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend item 1- State Registrar #14 per FH/wichd/11-15-06/d Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 13 0615 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner SALISBILA Nicomics If Under 1 Year | If Under 4 Hrs Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 56 Months Days Rhode Island Director death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 21804 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc.
White 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural". Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be မ Jawson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salisbury, md 21804 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State Flower Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address I Facility
Bennie Smith Funeral Home
Yil W. Isabella St. Sali Funyal Semice 21 Signatu 2/80/ Salisbury, md or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 16 CCULVENT /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by been signated 2 No 3 Probably 4 Unkhown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 1□ Yes or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient ို 1 Yes 2 No 2 ER/Outpatient 3 DOA this After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No hours after death. 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 13- 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Taylor M.O. 100 E. CAYOII JIMMY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 5 2006 Registrar Coart

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla		partment of F ertificate of			giene Reg. No.	106	38129
I	Physici		Decedent's Name (First, Middle, La FRANCES	BOWMAN		HOTTINGER		2. Date of De Month Novemb	Day	Year 2006	3. Time of Death 5:01 A ^M
	/Medio Examin		4a. Facility Name (If not institution, giv				r Location of Dea			ty of Death	J.01 A
	LXuiiiii		2801 Raleigh	Rd.		Walk	ersville		F-	rederi	ale
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs	. last birthd			S. 8 Date of Bir	th	G Ridhel	lace (State or Foreign
II.	Director		215-14-1460	□M 2⊠F 83	Yrs	. Moritis Days	Hours Mir	Novembe	ř 27, 1	922 N	aryland
	D .		Usual Residence of Decedent 10a, State 10b, County	100.0	ity. Town or	. I acation					
	aryla shov	ž	Maryland Frederi		,	sville				10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ne M	Director		,					10- 0:::		
	ath with the Marylan 23a or 28a-f show	ä	10e. Street and Number 2801 Raleigh Roa	d		10f. Zip Code 2179:	2		10g. Citizen o	/ What Count	try?
	eath	era	11. Marital Status	12. Was Decedent Ever in	18 1			Specify Ves or No		ace - America	an Indian
36	72 hours after death with the Maryland natural', or Items 23s or 28s-f show Jical Examiner must be notified at	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes, Give Year or Dates:	J.3.	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	an, Mexican, Pue	rto Rican, etc.)	Spec	lack, White, e	
215-0036	natural',	D e	15. Decedent's E		16a. De	ecedent's Usual Occup	pation		16b. Kind of	Business/Ind	Justry
<u>دا</u>	within 72 iene. then "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(G lift	ive kind of work done e. DO NOT use retire	during most of wo d)	orking			,
7	d with	E	12	College (1-401 37)	Exec	cutive Sec	retary		Alleg	heny P	ower?
	be filed ital Hygi of other event, I	ВеС	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden Suma	ıme)	
<u>a</u>	D 9 2 0	To	Howard Cover Bo	wman			Cora	Crumrine			
Maryland	~ ~ ~	1	19a. Informant's Name/Relationship (** '		ailing Address (Street					
	무를었는		John Hottinger -	husband ———————	280	l Raleigh	Road, Wa	alkersvil	lle, Ma	ryland	21793
ore O	S = = 0		20a. Method of Disposition 1 Surial 2 Cremation 3 C	Dameur from Chate	cemetery, o	sposition (Name of crematory or other pla	ce)	Date	20c. Location		
Ě	Pages ment of ant: If It ury or o		4 ☐Donation 5 ☐ Other (Specif	y) Mt.	Oliv	et Cemeter	cy 11-1	15-2006	Freder	ick, M	laryland
Baltimore,	permit. Page Department of Importent: If any Injury or once.		21. Signature of Funeral Source Licer	No tollu	0	22. Name and Address 1621 Oposs		Stauffer Pike, Fre			ne 71and 21702
H			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	th. Do not						Approximate Interval Between
	Physician		Immediate Cause (Final		-120	LE MUSCI					Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a conse		cc MOSEC	JUNE O.	15 TICOP	(et (years
	Examiner		Conventially list one distance	h							
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consa	quaries of).						
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events	c							
Š	e exe	Ξ.	resulting in death) Last	Due to (or as a conse	quence of):						
P8/P0	licate be executed physicien and s the burial-transit	edicai		d							
_	certific nding p	Me	IF FEMALE:	220 Hung gutagung of grand							
ŏ n	ath or u	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr	al death	3 Ectopic pregnancy	1			ate of deliver fonth	ry Day Year
oj.	0 0	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at time of 9 Unknown	oeatn	5 Other (specify)					•
7.	that (Part II. Other significant conditions of	contributing to death but not re	sulting in the	e underlying cause an	ren in Part I.	23e. Did to	obacco use coi	ntribute to the	e cause of death?
SD	w requires that the been signed by th should be detache	d by	CONCEST	WE WEART F	AL LUG	<u> </u>		101	res 2 No	3 Proba	ably 4 ⊟Unknown
ecords		Completed						24a. Was	an 24h	More outer	and findings available
ě	siclen: The law certificate has b irector, page 2 sl	Ę						autop		prior to com death?	osy findings available appletion of cause of
VITAI H	n: T) ficete or, pe		OF Man and referred to madical					1 Tes	2 No	1 ☐ Yes	2 No
5	Physiclan: this certific rat director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Mo	Hospital:	7500.4-	treat 3 DOA Oth	00	ath Check only o			
ō	at de de	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time	HEIL SELDON	4 🗀 Nursing i	Home 5 X Resid)
0	ding F th. After funera	ţ	1 Natural 5 Pending 2 Accident investigation		Injur		k? Yes 2∐No				
DIVISION	Attending F er death. rector: After by the funer	ertification:	3 Suicide 6 Could not b	e 28e. Place of Injury - At I	nome, farm,	street, factory, office		28f. Location (S	Street and Num	ber or Rural	Route Number,
S	al or	Cert	4 Homicide determined	building, etc. (Spec	ty)			City or Tow	vn, State)		
	To the Hospital or Attend within 24 hours efter death To the Funeral Director: / completely filled in by the fr	edicai (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example 1	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, de ation and/or	eath occurred at the tir r investigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and π date and place	nanner as sta , and due to	ated. the cause(s)
	ro th within ro th	Me	29b. Signature and title of certifier	\neg \uparrow		29c. Licens	e number		29d. Date sign	ed (Month, E	Day, Year)
	- > P O) /		D	3217			1310	5/
7	ا بر		30. Name and address of person who	completed cause of death (Ite	m 23a) (Tvi			•	(1)	1310	صدر
	`					•	28 6	AI WARS	ULLE	MO	21797
	Sta	te	31. Date filed (Month) Pay Year) 5	2006 32 Ustrarts Sign	atu	Aposte	<u> </u>	A PLANTAGE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	Registr	ar	1101 1								

		For State Registrar	Please I	State of M		d / Depa		t of H	lealth and		ital Hy		006	38130
Physic /Med		Decedent's Nam	e (First, Middle, Last)	linde							Date of De Month ovemb	ath Da	y Yea	3. Time of Death
Exami Funeral Director	ner	Citizens 5. Social Security N 220-56-3	503 ¹ X	lome	ge (In yrs. I	ast birthday) 55 Yrs.	4b. City, Frede If Under Months	eric	K If Under 24 Hrs Hours Min	S. 8.	Date of Bir (Month, Da	F ₁) (
anyland		Usual Residence o	Decedent 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Lim
with the Ma	Directo	Maryland 10e. Street and Nu		k	Walk	ersvi	10f. Zip					_	tizen of What	1 Yes 2 1
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or itams 23a or 28a-f ahow important: if Itam 27 is marked other than "natural", or itams 23a or 28a-f ahow any injury or other traumatic avent, Itam Medical Examinat must be inclined at any injury or other traumatic avent, Itam Medical Examinat must be inclined at any once.	by Funeral Director	11. Marital Status 1 Never Marital Status	ied 2X Married	12. Was Decedent Armed Forces 1 Yes If Yes, Give Year or Dates:	Ever in U.S No		2179 Was Deced	lent of H offy Cuba	ispanic Origin? (S an, Mexican, Puer Specify:	Specify nto Rica	Yes or No	US.		
in 72 hours	Completed		15. Decedent's Edu cify only highest grad	e completed)		(Give	dent's Usua kind of wor DO NOT us	rk done o	during most of wo	orking		16b. K	(ind of Busines	
12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "! fraumatic avent, It a Med	Be Comp		(First, Middle, Last)	College (1-4or	5+)	Sales			18. Mother's Na	ıme (Fi	rst, Middle	l	ck Rent	al
d Menta	ToB		loward Hind						Lois Jea					
nd 2 shallth and 27 is m			ame/Relationship (Ty Hinde/Wi	-					and Number or R ne Walke			-		, Zip Code)
permit. Pages Depertment of Important: If I any injury or o		4 Donation 21. Signature of Fi	XCremation 3 ☐ R 5 ☐ Other (Specify) uneral Service Licens the disease, or complete	e Ho	Che	.51 G	ke Cre	emat d Addres Home y L.	ory 11/ ss of Facility Cremati Heckrot	on te,	Servi P.A.	Bel ice		e, MD
death certificate be executed for use est the burial-transit of for use est the burial-transit	Examiner	Immediate Cause disease or condition resulting in death) Sequentially list confiant, leading to incause. Enter Under Cause (Disease or that initiated event resulting in death)	onditions, nmediate arlying injury Last	Due to (or as Due to (or as Due to (or as	MET s a consequence s a consequence	ence of):	47/C		LUNG		CARL	CIR	WM A	Interval Between Onset and Death MowTHS
that the death certificate bed by the attending physic detached for use es the b	by Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3[Ectopic pro		,				23d. Date of d Month	elivery Day Year
sign d be	d by Pi	Part II. Other signi	ficant conditions cor	ntributing to death t	but not resu	lting in the u	nderlying ca	ause giv	en in Part I,			obacco Yes 2		to the cause of death?
The ete h page	Completed										24a. Was auto perfo		prior to	
Attanding Physician: The I r death. sctor: After this certificete ha by the funeral director, page	Certification: To Be	25. Was case refeexaminer? 1 Yes 2 27. Manner of Dea 1 Natural 2 Accident 3 Suicide	No F	1 □ Inpati 28a. Date of Inju (Month, Da	ury ay Year)	ER/Outpatier 28b. Time o Injury	f 2	8c. Injun Wor	4 Mursing i	Home 28d	5 Resi	dence how inju	6 □Other (Sp	
2 2 2 0		4 Homicide	determined	building, e	tc. (Specify						City or To	wn, State	e)	Rural Route Number,
To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier (Check only one)	1∑ Certifying Phy: 2☐ Medical Exami	ner: On the basis of and manner si	of examinat	viedge, deat ion and/or in	h occurred a vestigation,	at the tin in my o	ne, date and place pinion, death occ	e, and urred a	due to the it the time,	date and	and manner d place, and d	as stated. ue to the cause(s)
To the within 2 To the complete	M	29b. Signature and	ifile of tentifier			M			e number 2649	9				3, 2006
) Jm		Ronald E.	Miller, N	M.D. 4 Cu	lwell	Dr.	P.O. 1	Box	210 Mt.	Air	у, М	21	771	
Regis	tate trar	2 2	NOV 1 4 2	006	we.	K A	bent							

DHMH 17 Rev 1/2001

			For State Registrar	State	of Marylan		artment of F				iene	16	381	3 1
			1. Decedent's Name (First, Middle	, Last)					2	Date of Deat		Van	3. Time of	Death
	Physici /Medio		David Leon	ard Ha	11				N	ovembe		2006	3:10	рМ
	Examin		4a. Facility Name (If not institution	_		_	4b. City, Town, o		of Death		4c. County			
П			Shady Grove A 5. Social Security Number	dventist 6.Sex	Hospita.		Rockvi		24 Hrs. a	. Date of Birth		gomer		r Foreign
	Funeral Director		500-52-6060	1⊠M 2□F		51 Yrs.	Months Days	Hours	Min.	ov. 10	1954	Unkn	ace (State o. try) OWN	ruieigii
	D		Usual Residence of Decedent								,			
	arylar	-	10a. State 10b. County			ty, Town or Lo						10	0d. Inside Cit 1 ☐ Yes	•
	the M	Director	Maryland Mon 10e. Street and Number	tgomery		North 1	Potomac 10f. Zip Code	_		1	0g. Citizen of N	What Count		
	Sa or	2	13511 Query Mi	11 Road			20878			'	_	d Sta	•	
	deeth with the Maryland me 23a or 28a-f ehow rmust be notified at	Funeral	11. Marital Status	12. Was De	cedent Ever in U	.S. 13.1	Was Decedent of H	lispanic Orig	gin? (Speci	fy Yes or No-	14. Rac	e - America	an Indian,	
٥	or Its		1 ☑ Never Married 2 ☐ Marr	ied 1 ☐ Yes	2 🔀 No		1 Tes, specify Cub 1 □ Yes 2 ⊠ No	an, mexican Specify:		can, etc.)	Specif	ck, White, e	etc.	
2-003b	hours after tural', or Ita al Examina	d by	3 Widowed 4 Divorced	Year or	Dates:							W.	hite	
ភ	in 72	Completed	(Specify only highe	T		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most	t of working	,	16b. Kind of B	usiness/Indi	lustry	
7 7	within piene r then	m o	Elementary/Secondary (0-12)	College	(1-4or 5+)		ility Wor	•			Farm	ing		
D	be filed within 72 hours after deeth with the Marylan hall tygiene. Id other than "natural", or lieme 23a or 28a-f show event, the Medical Examiner must be motified at	Be C	17. Father's Name (First, Middle,	Last)					er's Name (First, Middle, M	Maiden Suman	ne)		
ylan	should b nd Menta marked	10	Lou Hy11					An	ne El	der				
Mar	0 4 - 4	1	19a. Informant's Name/Relations				ng Address (Street							
_ ຜົ	1 end Heelth Bm 27 ther tr		Robert R. Pr	iddy / Co			Query Mi		ad, N		tomac,			
٥	00		1 ☐ Burial 2 ☑ Cremation		II State		esition (Name of matory or other place	i				•		. 1
	HE EE		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		r L		1n Crema							ına
ñ	Dep Per Sup Sup Sup Sup Sup Sup Sup Sup Sup Sup		NS.CD			S:	Name and Addre Lmple Tri 040 Rockv	bute :	Funera Pike.	al and Rockyi	Cremat	ion Co	enter	352
	E 430		23a. Part1 Enter the disease, or shock, or heart fail ire. List	complications that	t caused the deat								Approximate Interval Bety	9
	Physician		Immediate Lause (Final disease or condition	Atu	eroscie)	rotic	COMONO	ni d	vien	1 duc	PAR	75	Onset and D	leath U/
	/Medical Examiner		resulting in death)	Due to	o (or as a consec	tyence of):	ac.h	7		1			200	4
		100	Sequentially list conditions,	b. Due t	o (or as a conseq	Juence of):	45114		· .			- 1	yeur	15_
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,						1	
Ď	be executed icien and burial-transli		resulting in death) Last	Due to	o (or as a conseq	quence of):								
2/PU	e ys	ical		d										
ã	leath certificate ettending physi I for use as the I	by Physician/Med	IF FEMALE:	220 11 1100	utcome of pregna									
X Q Q		cian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ☐ Feta gnant at time of d	al death 3[Ectopic pregnancy Other (specify)	у				te of deliver onth [•	/ear
j.	the d	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unk		JOURN 30			-					
ري ح	w requires that the death been signed by the ette should be deteched for	Z P	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.		23e. Did tob	acco use cont	ribute to the	e cause of d	eath?
ecords,	equire en siç ould b									1 □ Ye	s MNo	3 🗌 Proba	ably 4 □U	Inknown
ပ္မ	a a	Completed								24a. Was a		Were autop	sy findings a	available
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Vital	Physician: Th this certificete ral director, peg	Be	25. Was case referred to medica examiner?	Hospital:		_	- 20 BOA O#	200		Check only on				
0	Phys rthis ral dii	5.7	27. Manner of Death	1		ER/Outpatier 28b. Time o	IL 3L DOA	4 🗌 NU			ince 6 Oth)	
0	nding tth: :: Afte e fune	atlor	1 Natural 5 Pendir	'9	e of Injury onth, Day Year)	Injury	Wor	rk? ∣Yes 2⊡I			,,			
Division	Atternation	Certification;	3 Suicide 6 Could 4 Homicide determ	inad 288. Plat	ce of Injury - At h	ome, farm, str	eet, factory, office		28	f. Location (St. City or Town	reet and Numb	per or Rural	Route Num	ber,
5	ital or rs aft al Dir	Cer			ding, oto. (opour						, 51216)			
	he Hospital or Attending Ph in 24 hours after death. he Funeral Director: After th pletely filled in by the funeral	Medicai	(Check only /2 Medical	ng Physician: To the Examinar: On the	basis of examina	owledge, deat ation and/or in	h occurred at the til vestigation, in my o	me, date an opinion, dea	nd place, and th occurred	d due to the ca at the time, da	ause(s) and ma ate and place,	anner as sta and due to	ated. the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifie	and ma	inner stated.		29c. Licens				9d. Date signe			
	F ≯F 8 Ii) Drein	(Men	1 Mi		74	7-0	93		Joven		06	Look
-	4		30. Name and address of person	who completed ca	use of death (Iter	m 23a) (Type,	Prin()	0 1	1				J 4 1	000
			Martin Ma	- Grew	4 990	Ol Me	dical	Ceur	er Di	TWE P	ockull	e Mi	D 20,	850
		ate	31. Date filed (Month, Day, Year)	5 2006	Begistrar's Signa	ature &	ast, i							
	Regist	Idi	140 A T	, 2000	COUNTY 1	2. W								

DHMH 17 Rev 1/2001

			1 - For State Registrar		State of Ma	aryland / l		artment of H <i>tificate of I</i>		and Mer		gienez Reg. No.	006	38132
	Physici	an	Decedent's Name (A T. T.C.)		HADDAWAY						Date of De Month	Day	Year	3. Time of Death
	/Medic Examin	cal	4a. Facility Name (If n					4b. City, Town, or	Location o		ov.	21 4c. Ce	2006 ounty of Death	10:09A M
	Examin	iei			ce House			Eas					Talb	o.t.
	Funeral Director		5. Social Security Num 215-35-1		9x 7. Age	(In yrs. last bir		If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Bir (Month, Da	y, Year)	9. Birth	place (State or Foreign ntry)
	<u>p</u>		Usual Residence of D							D	ec.z	,1936		yland
	arylar ehow	_		10b. County		10c. City, Tow	n or Lo							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
:	the M.	ecto	MD 10e. Street and Numb	Tall	oot			Tilg	nman			10a Citian	n of What Cou	
	death with the Maryland me 23a or 28a-f ehow ritual be notified at	ă		~. Camper	Circle				571					States
	death	Funeral Director	11. Marital Status		12. Was Decedeni I Armed Forces?	Ever in U.S.	13. V	Vas Decedent of Hi f Yes, specify Cuba		gin? (Specify	Yes or No		. Race - Ameri	can Indian,
0000	s 1 and 2 should be filed within 72 hours after death with the Marylar If Health and Mental Hygiene. If Health and Mental Hygiene them 23a or 28a-f ehow fother treumatic event, it a Miculcal Exaction mainter colling at	þ	1 Never Married 3 Widowed 4		1 Yes 2 区 N If Yes, Give Year or Dates:	lo	1	Yes 21 No		i, Puello Alca	in, etc.)		Black, White, pecify: Wh	
ה ה	72 hc	eted	1 (Specify	5. Decedent's Ed	lucation de completed)	16a.	Deced (Give	lent's Usual Occupa kind of work done of OO NOT use retired	ation during most	t of working		16b. Kind	of Business/In	dustry
7	12 should be filed within nand Mental Hygiene. Fis marked other than "ireumatic event, tra Me.	Completed	Elementary/Second	dary (0-12)	College (1-4or 5	+)				3		Ov	vn Ho	me
מ כ	filed Hygie other		17. Father's Name (Fi	irst, Middle, Last)			1101	memaker	18. Mother	er's Name (Fi	rst, Middle,			
<u>a</u>	Aental Aental rked (To Be	Warre	n Milto	n Lowery				Ann	nie I	sabe:	11e N	Vewnam	
	2 shot and N is ma		19a. Informant's Nam		•	19b	. Mailin	g Address (Street a						Code)
≥ .	and and lealth		John Ha		Husband	F	0.9	Box 26	54, I	Tilghi	man,		21671	
	or of			Cremation 3	Removal from State			sition (Name of natory or other place		Date			ition - City or To	
Dallinor	permit. Pages Depertment of the important: If ite eny injury or of once.		4X Donation 5 21. Signature of Fune			Anato		Gift Re			/06	Han	over,	MD
ם מ	Depermi Depermi import eny ir		Chri	stine	M. Co	le					Hom	e, Fe	ederal	sburg, MD
			23a. Part1. Enter the shock, or heart to	disease, or comp failure. List only	olications that caused one cause on each lin	10.								Approximate Interval Between
F	Physician		Immediate Cause (Fi disease or condition resulting in death)	nal	a			FULTIVE	= Puu	MONAD	4 01	SZAS	it	Onset and Death
E	/Medical Examiner		, and a second	ſ	Due to (or as	a consequence	of):							
		Jer	Sequentially list cond if any, leading to imm cause. Enter Underly	ediate	b. Due to (or as	a consequence	01):							
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ָה ה	w requires that the death certif been signed by the attending should be detached for use a	Physician/M	in the past 12 m 1 Yes 2 12 f		4□Pregnant at			Ectopic pregnancy Other (specify)				i	Month	Day Year
	hat the		9 Unknown Part II. Other signification	ant conditions co	ontributing to death bi	ut not resulting in	the un	iderlying cause give	n in Part I		23e Did le	nhacco use	contribute to t	he cause of death?
ģ.	uires l signe d be	d by			, , , , , , , , , , , , , , , , , , ,	g		idonying addoorgive			1 (20)			pably 4 Unknown
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2	Atter	Certification;	3 Suicide	6 Could not be determined		iry - Al home, fa	rm, sire	eet, factory, office					Number or Rura	al Route Number,
5	urs after			2	4						City or Tov			
:	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 (Check only 2 one)	☐ Certifying Ph	ysician: To the best of niner: On the basis of and manner sta	examination an	dor inv	occurred at the tim restigation, in my op	e, date and pinion, deat	d place, and th occurred a	due to the t the time,	cause(s) an date and pl	nd manner as s ace, and due to	tated. o the cause(s)
ı	P S F F F F F F F F F F F F F F F F F F	Σ	29b. Signature and tit		Ala.			29c. License		2			signed (Month,	
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			30. Name and addres	x 1. 6	ATRINSON	J mis	8	800 S. TA.	BUT	क्षा ९	ST. M	ICHA	ecs v	w
	Sta Registr		31. Date filed (Month,	Day. Year)	32. Registra	r's Signature	433	A)						

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Andre Michael Imperial State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Medical Examiner 0430 hrs November 9, 2006 Andre Michael Imperial 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3101 Wppd Avenue Burtonsville Montgomery 5. Social Security Number 6. Sex 7, Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreigrWashington, Hours Director 2 F 02/12/1945 1 X M 213-76-1146 61 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits s 23a or 28a-f show e notified at once. Yes 2 No <u>Mar</u>yland Burtonsville Pages 1 and 2 should be filed within 72 hours after death with the Maryland Montgomery Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 3101 Wood Avenue 20866 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black Armed Forces? White etc. 1 X Never Married must Yes White 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify event, the Medical Examiner þ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 5+ N/A None 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Marie Lillian Andersen Jose Fabiano Imperial 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and A Important: If item 27 is m injury or other traumatic Jose F. Imperial - Brother 3101 Wood Avenue, Burtonsville, Maryland 20866 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Baltimore, crematory or other place) timore Crematory at Loudon Park Burial 2 X Cremation 3 Removal from State Donation 5 Other Spe 11/15/2006 Baltimore, Maryland Signature of Funeral Service L 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silve the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear ring MD
Approximate Interval Part I. Enter Physician failure List o one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Atherosclerotic Cardiovascular Disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED use as the burial **AMENDED** Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death Other (Specify 1 Yes 2 No 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performe death? Yes 2 V No 25. Was case referred to medica 26.Place of Death (Check only one) Be Hospital: 1 Other₄ DOA Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene ဥ 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: ✓ Natural Yes 2 No Pending the Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical within 2 To the I 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. November 9, 2006 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (1974). Day Yes State 2006 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month P^{M} Mary Catherine Jackson 12 2006 November 2:15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (S. Country)
July 22, 1925 Georgia 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 □ M 2 🔀 F 258 28 5430 81 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 1 ☐ Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 2809 Leaf Shade Dr. USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married 2K No White 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Office Manager Wallpaper Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifford Shroyer Mary Gossett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16 Holly Rd. Severna Park, MD 21146 19a. Informant's Name/Relationship (Type. Print) Cheryl Mack/daughter Severna Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/17/2006 | Cheltenham, MD Cheltenham Veterans 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licenses M01442 4112 Old Columbia Pk. Ellicott City, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Candio hour disease or condition resulting in death) Due to (or as a consequent of) CVA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as the interest of the cause) Due to for as a consequence of): resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 🗵 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2**X** No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 SER/Outpatient 3 DOA 28a. Date of Injury (Month, Day) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner

death certificate be executed

The law requires that the

or Attending Physician:

To the Hospital of within 24 hours af To the Funeral D

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Division or Vital Records,

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should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

and Mental Hygiene.

Pages 1 and 2 s ment of Health an ant: If Item 27 is 1

permit. Pages 1 and 2 Department of Health Important: If Item 27 any Injury or other tra

Examiner the burial-trar funeral director, nours after death.

neral Director: #

by Physician/Medical Be

Completed

Certification: To

Medical

1 Natural 2 Accident

3 ☐ Suicide 4 Homicide

29b. Signature and title of certi

29a. Certifier

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Ellicott City, MD

29d. Date signed (Month, Day, Year) November 13, 2006

10298-B Baltimore Nat'l Pike

who completed cause of death (Item 23a) (Type, Print)

2006

31. Date filed (Month, Day,

14

NOV

Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygieney 38135 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 10, 2006 Physician Martha Gladys 3:00P. M Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Prince George's Laurel Regional Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 19, 1912 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Mary Land **Funeral** Months 94 218-24-3192 1 ☐ M 2 □XF Director Usuat Residence of Decedent the Maryland 10h County 10c. City, Town or Location permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene.
Important: If item 27 is marked other than "naturs!", or items 23a or 28a-f show any Injury or other treumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits Beltsville Maryland Prince George's 1 Yes 2 No Director 10f. Zip Code 20705 10e. Street and Number 4706 Prince George's Avenue 10g. Citizen of What Country? United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White à Yes, Give 'ear or Dates: 3 ☐ Widowed 4 ₺ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Control Data Processor Arbitron 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Flora Hinton Mary James 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4706 Prince George's Avenue Beltsville, Maryland2070 Donald Wolfe -son in law 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 11/14/2006 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donald Vor Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Qnset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) oronar 1tars /Medical Due to (or as a consequence of) Examiner repro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of) Examine ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Bot 230(B) of Der V. Terry (Brud Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9☐ Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an certificate has blirector, page 2 s autopsy performe 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 2 No 1 Tes 6 ☐ Could not be 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 11, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Armstron 14201 Laurel PK, Dr. #102 Laurel, MO 20707 M.D. 31. Date filed (Month, Day, Year) NOV 1 5 2006 State

Registrar

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	partment of Hertificate of I		Mental Hygie Reg	ZUU	6 38	136
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	/Medic	al	Veikko Akse		ppo	45 025 7				006 10:	40 p ^M
	Examin	er	4a. Facility Name (If not institution, give 15101 Interlache				r Location of Death Spring		4c. County of	gomery	
	Funeral		Social Security Number 6. S	9x 7. A	ge (In yrs. last birthda	/) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State	e or Foreign
l.	Director		100-30-4900	M 2□F	89 Yrs.	Months Days	Hours Min.	(Month, Day, Y. Aug. 30,	1917	Finland	
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside	City Limits
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	h the	Director	10e. Street and Number	шсту	BIIVEI	10f. Zip Code		10g	. Citizen of Wh	nat Country?	
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	tams	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, White, etc.	
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Ž	2 should be and Mental Is marked a	ပို	Unknown 19a. Informant's Name/Relationship (7)	vpa Print)	19h Ma	ling Address (Street a	Unknow		ity or Town St	lata Zin Code)	
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Ë	Page ment o ant: If ury or		1 ☐ Burial 2X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			oln Cremat	, I	7/2006 B	rentwoo	od, Maryl	Land
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or othar ance.		21. Signatule of Funeral Service Linen:	500)	S	22. Name and Address imple Trib	ss of Facility Oute Fune	ral and C	rematio	on Center	
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			shock, or heart failure. List only o	one cause on each	ine.		1 .	1 1		Approxim Interval B Onset an	Between
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Ţ	Physicien: this certific ral director,	To B	examiner? 1 🗆 Yes 2 No	Hospital: 1 🔲 Inpati	ent 2 ER/Outpatie	ent 3 DOA Othe	200	ome 5 Aesidence	e 6 Other	(Specify)	
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Di≤	after Direction by	ertification;	4 Homicide determined	building, e	jury · At home, farm, s tc. (Specify)	treet, lactory, office		28f. Location (Stree City or Town, S	tate)	or Hura; Houte Nu	moer,
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	the Ho In 24 Tha Fu	edicai	(Check only 2 Medical Exam	and manner st	of examination and/or i ated.	nvestigation, in my or	pinion, death occur				
	within To the comple	Σ	29b. Signature and title of certifier	- D	M M.	29c. License	number	29d.	Date signed (/	Month, Day, Year)	
,	15		Tatucia 16	msko	July, M	W 1	1/10	11	113/	2006	
			30. Name and address of person who co	ompleted cause of	death (Item 23a) (Type	119 ROLA	kville,	Pike G-11	00. Ron	Kville M	D20851
	Sta	te '	31. Date filed (Month, Day, Year)	32 Regist	ar's Signature	act B		110/0 /1	J RUCI	VIII III	AT OFFICE
	Registr	ar	NOV 15 20	Nb Mar	N St. 189						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Julian George Murphy Дм 2:40 November 8, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Genesis Eldercare Spa Creek Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1⊠M 2□F 111-22-1859 86 Director Dec. 6, 1919 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28s-f ahow any injury or other traumatic event, the Medical Evertheat must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Annapolis Maryland **Funeral Director** MYes 2 No 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 172 Acton Road 21403 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married Yes 2 No Yes, Give Year or Dates: 1942–46 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 4 Insurance Broker Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Murphy Grace Birgfeld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Murphy/wife 172 Acton Road Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Crematory 11/10/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signatura Juneral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) archac Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) ettending physician Physician/Medical use as the IF FEMALE . If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 Probably 4 Whknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 12 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) မ 1 🔲 Yes 2 No 3 DOA this 27. Mann Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: After Natural after death.

f Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Medical

within 24 hours a To the Funeral [

29a. Certifier

(Check only one)

29b. Signature and the of certifier



ss of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

			1- State 11/9/06 AACO HEALTH CMH Certificate of D	alth and Mental	Hygiene Reg. No	2006 38138
	Physici /Medic			2. Date Mont Nove		Year 3. Time of Death 720M
à	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or L 1423 Howard Road Ann	apolis	40	County of Death Anne Arundel
	Funeral Director		175–54–2827 XXM 2□F 36 Yrs. Months Days	If Under 24 Hrs. 8. Date Hours Min. (Monitoring Marc	of Birth th, Day, Year) h 22,	9. Birthplace (State or Foreign Country) 1970 Pennsylvania
	Maryland f ehow	lor	Usual Residence of Decedent 10a. State 10b. County Anne Arundel 10c. City, Town or Location Annap	polis		10d. Inside City Limits 1 ☐ Yes 孝쪽No
	3e or 28e	I Director	10e. Street and Number 10f. Zip Code 1423 Howard Road 2	1403	10g. Ci	tizen of What Country? U.S.A.
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mentel Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, the Madical Ext. Junet can be inclided at	by Funeral	3 Widowed 4 Divorced Year or Dates:	panic Origin? (Specify Yes Mexican, Puerto Rican, et Specify:	or No- c.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	I within 72 ho iene. r then *natur the Madical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 16a. Decedent's Usual Occupati (Give kind of work done du life. DO NOT use retired) Police Office	ring most of working		(ind of Business/Industry Enforcement
/land 2	should be filed ind Mentel Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last)	8. Mother's Name (First, N Nanci Cmast		
	end 2 sho ealth and n 27 is mu		19a. Informant's Name/Relationship (Type, Print) April McKinley/wife 19b. Mailing Address (Street an 1423 Howard R			
Baltimore,	permit. Peges 1 in Department of He Important: If item any injury or oth once.		20a. Method of Disposition 1	1		ocation - City or Town, State 1timore, Maryland
Balt	permit. Departr importe any inje					r Funeral Home apolis, MD 21401
1	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death
	/Medical Examiner		Sequentially list conditions b)		
	and Il-transit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):			
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.O. Box (The law requires that the death certific ate has been signed by the attending p page 2 should be deteched for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 2 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		-	23d. Date of delivery Month Day Year
۵.	quires thet the signed by all did be detected	þ	Part ii. Other significant conditions contributing to obtain but not resulting in the underlying cause given	in Part I. 23e.		use contribute to the cause of death?
Division of Vital Records,	: The law requir cate has been si . page 2 should	Completed			Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Zi Zi	Physician: r this certific ral director.	To Be	exagniner?	26. Place of Death Check		6 ☐Other (Specify)
on o	Attending Phradest. r death. ector: After thi				cribe how inju	
Divis	of te	Certification;	3 & Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building fetc. (Specify)		tion (Street a or Town, Stat	nd Number or Rural Route Number,
	To the Hospitel or within 24 hours effer To the Funerel Dir completely filled in In	edical (date and place, and due to nion, death occurred at the	to the cause s time, date an	s) and manner as stated. d place, and due to the cause(s)
)	To the within 2 To the comple	Me	20h 0:	number 06054	29d. Da	ate signed (Month, Day, Year)
	ID		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Ameri	CA	27035
	Sta Regist		31. Date filed (Month, Day, Year) 32. Segistrar's Signature			

			For State of Maryland / Depar		f Health and I of Death		2000	38139
	Dhysisi	4	Decedent's Name (First, Middle, Last)	nouto c	, Douth	2. Date of Dea	Reg. No. ath Day Year	3. Time of Death
	Physici /Medic	al .	4a. Facility Name (If not institution, give street and number)	th City Toy	n, or Location of Death	11	14 200 &	
	Examin	er	Atlantic General Hospital	_	rlin		Worcester	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Ye		(Month, Day	th 9. Birti	nplace (State or Foreign
			Usual Residence of Decedent			Sept. 1	9, 1929 1	llinois
	Marylar f ahow	or	MD Worcester Ocean Pine					10d. Inside City Limits 1 ☐ Yes 2€XNo
	n the h	irect	MD Worcester Ocean Pine 10e. Street and Number	10f. Zip Cod	de		10g. Citizen of What Co	
	ath wit	Funeral Director	13 Quarter Staff Place		811		USA	
036	permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28a-f ahow any injury or other traumatic avent, it e M. dical Examiner must be multified at once.	by	Armed Forces? If Y 1 □ Never Married 2 ★ Married 1 ★ Yes 2 □ No.	as Decedent 'es, specify (of Hispanic Origin? (Si Cuban, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)	- 14. Race - Ame Black, White Specify: Whi	e, etc.
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pue	be file ntal Hy ed othe avent,	Be	17. Father's Name (First, Middle, Last)				Maiden Sumame)	
Maryland	should nd Mer marke	To	George Matha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing.	Address (Str		ailable Ira/ Route Numbe	er, City or Town, State, Z	ip Code)
Ĕ	and 2 ealth a m 27 is						n Pines, Md	
Baltimore,	ages 1 nt of H t: If ital		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, crematically compared to the	tory or other	place)	Date	20c. Location - City or	
altin	mit. P partme portani r injury		^4 □ Donation S □ Other (Specify) Cape Hen10 21. Signeture of Funeral Service Licensee 22. N			15-2006 Burbage	Frankford, Funeral Ho	me
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24 7 7 1 Re	The lay	Completed				24a. Was a autop: perfor 1 Yes	sy prior to co	opsy findings available ompletion of cause of
Wita Vita	ysiciar is certif directo	o Be	25. Was case relerred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	3□ DOA	Othor	th (Check only or	ne) lence 6 Other (Spec	ifu)
On of	ing Ph After thi uneral	on: I	27. Manner ol Death 1 ☑ Natural 5 ☐ Pending 28a. Date ol Injury (Month, Day Year) Injury 28b. Time ol Injury	28c. lr	njury at Work?		ow injury occurred	'''
Picha 164 Divisio	death death ictor: /	ertificati	2 Accident investigation 3 Suicide 6 Could not be determined determined		1 ☐ Yes 2 ☐ No	28f. Location (S	treet and Number or Rui	al Route Number.
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	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) 1	courred at the tigation, in m	e time, date and place, ny opinion, death occur	, and due to the c rred at the time, d	cause(s) and manner as a date and place, and due	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	29c. Lic	ense number		29d. Date signed (Month)	Day, Year)
			Engrammas M2 Attending	D56	6312	/	11/14/2006	
ST "	8+1		30. Name and addices of person who completed cause of death (Item 23a) (Typé, Pri Gregory W. Stamnas, MD 9733 Haalt	hwas	Drive Berli	n, MD 2	-1811	
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri Gregory W. Stammas, MD 9733 Healt 31. Date filed (Month, Day, Year) NOV 15 2006 32. Resistrar's Signature	الماد				

			For State Registrar	State of	Marylan				lealth a Death	nd M	ental Hy	gienę. Reg. No.	2006	3 8	3140
	Physici	an	Decedent's Name (First, Middle, Last)	-							2. Date of De		- Xea	3. Tim	e of Death
	/Medic	al	Elaine 4a. Facility Name (If not institution, give s	treet and numb	harl		Meyer		r Location of		Novemb		2006 County of De		OP. M
	Examin	er	Joseph Richey Hos		561)				nore C			40. (none	auri	
	Funeral Director		5. Social Security Number 6. Sex 205-16-8221	7]M 2XF	. Age (In yrs. 8	last birthday) 2 Yrs.	If Unde Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, Da March6	rth ay, Year) 5,1924	9. B 4 Pe	irthplace <i>(Sta</i> Country) nnsy1v	ate or Foreign ania
	ne Maryland 8a-f ehow	ctor	10a. State 10b. County Maryland Prince Ge	orge's	10c. Cit Bow	y, Town or Lo 7ie	ocation							iX:	e City Limits Yes 2 No
	ath with the 23a or 2	Funeral Director	16010 Excalibur Ro	ad, #B3	303		10f. Zip	2071	L6				en of What on ited	Country? States	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel; or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	ρ	11. Marital Status 1 □ Never Married 2 □ Marned 3 🎇 Widowed 4 □ Divorced	12. Was Deced Armed Forc 1 ☐ Yes 2 If Yes, Give Year or Dat	es?	+	Was Dece If Yes, spe 1 Yes	**	ispanic Orig in, Mexican, Specify:	in? (Spe Puerto f	cify Yes or No Rican, etc.)		Black, Wh	nerican India nite, etc. White	n,
Maryland 21215-0036	d within 72 ho piene. r then "netu ing Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		4or 5+)	16a. Deced (Give life.	kind of wo DO NOT u	rk done d se retired	ation during most f)	of workin	ng		d of Busines	s/Industry	
/land	uld be filed Mental Hyg irked othe itic event,	To Be C	17. Father's Name (First, Middle, Last) Myer Rosenberg				*		18. Mother Mary	-	(First, Middle .n	, Maiden S	Sumame)	· •	
, Mar	and 2 sho salth and I n 27 ie mu		19a. Informant's Name/Relationship (Typ. Suzanne Crane -dau			19b. Mailir 12415	Sky]	(Street a	and Number Lane	or Rura Bowi	Route Numb .e, Mar	or, city or ylanc	Town, State,	, <i>Zip</i> Code) 5	
Baltimore,	Pages 1, nent of He ant: If iten ury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from St		Place of Disponentery, crered to Control Contr	natory or c	ther plac	ial P		ate 11/9/2			ills,P	
Balt	permit. Departr imports any inj		21. Signature of Funeral Service License Donald	Ba	que as	₩ 50 4	611213 400 I	r Addres Powde	Borgw er Mil	ardt 1 Ro	Funer	al Ho	ome, P.	A arvlan	d20705
•	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on eac	ch line.	ung			g, such as c	ardiac or	r respiratory a	rrest,		Onset a	mate Between and Death
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{ rds, P	w requires tha been signed I should be det	Ď	Part II. Other significant conditions con	tributing to dea	th but not resi	ulting in the u	nderlying c	ause give	en in Part I.			obaccous Yes 2 □	\ \	to the cause robably 4	
/ಆಳ್ವರ್	a se s	e Completed	25. Was case referred to medical							_	1 ☐ Yes	psy ormed!! 2 No	prior to death?	autopsy findir completion s 2 No	ngs available of cause of
on of	Jing After fune	ToB	examiner?	ospital: 1 Inp 28a. Date of (Month,	oatient 2 Injury Day Year)	ER/Outpatien 28b. Time of Injury		8c. Injury Work	er: 4 ☐ Nurs	sing Hom	Check only one 5 Residence 8d. Describe	dence 6		ecity 25	Dice_
Jaine Division	tal or Attendi s after death. el Director: A ed in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	f Injury - At ho g, etc. (Specify	ome, farm, stre	eet, factory	r, office		2	8f. Location (City or To	Street and wn, State)	Number or F	Rural Route N	lumber,
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			30. Name and address of person who con	The sales	SOLCS	23a) (Type, 1	Print)	uta	wst-	R	altim	852	Mo-	ו מי בני	
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DHMH 17 Rev 1/2001

			For State Registrar	;	State o	of Maryl	and / Dep <i>Ce</i>	artme ertifica	ent of H	lealth a	and M	ental Hy	giene Reg. No		16	38141
			1. Decedent's Name (First, Mid	dle, Last)								2. Date of De	aath			3. Time of Death
	Physici /Medio		Cynthia Lynne 1	McAli	ster							Month Novemb	Da er 8		Year 06	6:10 p M
	Examin		4a. Facility Name (If not instituti	on, give sti	eet and nu	ımber)		4b. C	ity, Town, o	Location	of Death		40	. County	of Death	
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	Funeral		5. Social Security Number	6. Sex	v 2 X ∃F	7. Age (In) 65	yrs. last birthdaj Yrs.	/) If Un Monti	der 1 Year ns Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year)		Cou	
	Director		329-34-7059 Usual Residence of Decedent								.	June 2	6, 1	941	Tex	as
	yland yland		10a. State 10b. Coun	ty		10c	City, Town or I	ocation								10d. Inside City Limits
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	or 28	Oire	10e. Street and Number					10f.	Zip Code				10g. Ci	tizen of W	/hat Cou	ntry?
	ath w	rai	22908 Timber						871					ted S	Stat	es
	er de Items	Funeral Director	11. Marital Status		Armed F		n U.S. 13	. Was De If Yes, s	cedent of H pecify Cuba	ispanic Ori n, Mexicar	igin? (Spe n, Puerto f	cify Yes or No Rican, etc.))-		- Ameri k, White,	can Indian, etc.
36	irs aft	by F	1 ☐ Never Married 2 💢 Ma 3 ☐ Widowed 4 ☐ Divorce		1 ☐ Yes If Yes, Gi Year or D	ive		1 ☐ Yes	2 X No	Specify:				Specify:	Whi	te
21215-0036	within 72 hours after death with the Maryland one. than "naturel", or items 23e or 28e-1 show the Medigul Essi is at most be notified at		15. Decedo		ition				sual Occup				16b. K	(ind of Bu	siness/In	dustry
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2	should nd Men marke umaric	²	Charles Edward				401.44					es Cre				
Maryland	01 (0 0)		19a. Informant's Name/Relation Archie J. McA									Route Numb e, Clai				,
	of Health item 27 i		20a. Method of Disposition			20	b. Place of Disp	osition (i	Vame of			ate				own, State
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alti	mit. I partm sortei / inju		21. Signature of Fune al Service		1 1/	^		22 Name	and Addres	e of Eacilit	ts.r					
ä	Depar Depar Impo		leri Ama	There	h- Th	alex								e Pil	ce,	Rockville,
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complica	ations that	caused he d	leath. Do not e	nter the n	node of dyin	g, such as	cardiac or	r respiratory a	rrest,			Approximate Interval Between
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	/Medical Examiner		resulting in death)	(Due to	(or as a con	sequence of):									
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9	rtifical ng phy as th	0	IE EEN E													
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Vital	(0)	e Cc	25. Was case referred to medic	eal						OC Disease	of Dooth	1 Yes	2/2 No	1	Yes	2□No
	Physicien: this certific ral director,	OB	examiner? 1 ☐ Yes 2 ☐ No		spital: 1 🗆	Inpatient	2 🗆 ER/Outpatie	ent 3	DOA Othe	200		Check onl		6 □Othe	r /Snecit	iv)
n of		n: T	27. Manner of Death	tion of	28a. Date		28b. Time		28c. Injun	at		8d. Describe				,,
Sio	Attending r death. ector: After by the fune	atic	2 Accident inves	tigation			,,,	М		Yes 2	No					
Division	or Atl fter d Direct in by	Certification:	3 Suicide 6 Coul 4 Homicide deter	mined	28e. Place build	e of Injury - / ing, etc. (Sp	At home, farm, s ecify)	treet, fact	ory, office		2	Bf. Location (City or To	Street ar wn, State	nd Numbe e)	r or Rura	al Route Number,
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	To the within Fo the xom, i	M	29b. Signature and title of certification	ier /					29c. License	number			29d. Da	te signed	(Month,	Day, Year)
)			> (us un						531	77		and the state of	بال مري	113	والم	006
	<i> </i> >		30. Name and address of person	n who com	pleted cau	se of death (Item 23a) (Type	, Print)	- /							
			CDR. John		allo	lark	970	7 1/4	die	1 (4	reter.	DR	w i	acke	ille	140,000
	Sta Registr		31. Date filed (Month, Day, Yea NOV 1	5 200		Registrar's S	ignature	BILL	7							1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ○ ○ ○ Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November T3, 2006 Jane Elizabeth 5:30A. M Mason 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Vantage House Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign October 30, 1912 Washington, DC 5. Social Security Number 7. Age (In vrs. last birthday) Months 1 □ M 2X F 217-34-1904 94 Yrs Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Columbia Maryland Howard 1 ☐ Yes 2X No 10g, Citizen of What Country? 10e. Street and Number 10f. Zin Code 5400 Vantage Point Road United States 21044 Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify White Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Watkins Wilbur Alice Bronson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43 Old Solomons Island Road Lothian, Maryland20711 Donald V. Mason -son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 11/14/2006 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 la 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RIN 8100 Due to (br as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) STOREV Due to (or as a consequence IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed? 1 ☐ Yes 2 ☐ No 2**X** No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence of Other Companied Care CL Hospital: 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Examiner Examiner burial-transit to the Hospital or Attending Physicien: The law requires thet the death certificate be executed anding physicien a use as the burial-Box 68760, attending p for use as ed by the detected Division of Vital Records, P.O. cete hes t page 2 s director, ٥ this is After after death.

I Director: Af
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Physician

/Medical

Examiner

Funeral

Director

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Funerai Director

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I Hygiene.

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permit. Page Department of Important: If eny injury or once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Physiclan/Medical δ Be Completed Certification: 29a. Certifier Medical

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide

(Check only one)

29b. Signature and title of certifien

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

7/ M will

D55425

29d. Date signed (Month, Day, Year) November 13, 2006

30. Name and address of person who completed cause of dea h (Item 23a) (Type, Print)

Willie B. Myemba, M.D. 413 Common Wealth Avenue Catonsville, Maryland 21228

Registrar

31. Date filed (Month, Day, Year) 2006 15 NOV



10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day NOVEMBER 11, 2006 **Physician** Α. MADGWICK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HILLHAVEN NURSING HOME ADELPHI PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 78 DECEMBER 26, 1927 SCOTLAND Director 217-38-4286 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show an "natural", or Items 23a or 28a-f shov Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MARYLAND MONTGOMERY SILVER SPRING 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 501 E. WAYNE AVENUE U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: WHITE ģ 3 \ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) th **EDUCATOR** EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fil Health and Mental H tem 27 is marked oth Be ပ MADGWICK **ISABELLA** HOGG traumatic WILLIAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA ANN MADGWICK/DAUGHTER 501 E. WAYNE AVENUE, SILVER SPRING, MARYLAND 20901 Important; If Item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ment of F 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) LOUDON PARK CREMATORY 11/15/2006 BALTIMORE, MARYLAND 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC 21. Signature of Funeral Service Licensee udewi 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCLEROTIC CARDIOVASCULAR DISEASE 15 YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-tran Due to (or as a consequence of) physician as the burial Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 **ASTHMA** 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed CHRONIC OBSTRUCTIVE LUNG DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No cate has I autopsy performed certificate 2 X No After this certification funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No ပို 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 X Natural n 24 hours and the the the function of the fun 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 29b. Signature and title of certifile 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

filed within 72 hours after death with the Maryland

Maryland 21215-0036

3altimore,

law requires that the death certificate be executed

Box 68760,

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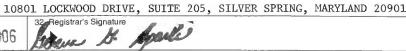
Division or Vital Records,

To the Hospital or Attending Physician:

31. Date filed (Month, Day, Year) VON 15

CHARLES BENNER, M.D.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D0031563

NOVEMBER 14, 2006

			1- For State of Mary		artment or <i>rtificate</i>				Reg. No.	38144
	Physici	an	1. Decedent's Name (First, Middle, Last) Charles Ray Mullinex					2. Date of D Month	Day Y	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, To	wn, or Lo	cation of E		ber 22, 20	
	Exami	iei	Julia Manor Health Care Cente	er			ersto			shington
	Funeral		169M 2□E	yrs. last birthday) Yrs.	If Under 1 Months D		Under 24 Hours	Min. 8. Date of Bi	rth 9	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	0 115.				UCL. 20	, 1940 We	est Virginia
	uryland	_		c. City, Town or Lo						10d. Inside City Limits
	he Ma	ecto	Md. Washington	Ha	agersto					1 Mayes 2 □ No
	with t	2	10e. Street and Number 64 W. Church St.		10f. Zip Co	21 7 4	10		10g. Citizen of Wha	S.A
	72 hours atter death with the Maryland natural', or items 23a or 28a-f show disal Examiliat mail be Indilliad at	Funeral Director	11 Marital Status 12. Was Decedent Ever	r in U.S. 13.	Was Deceden	nt of Hispa	anic Origin	? (Specify Yes or No Puerto Rican, etc.)		American Indian,
36	or ite	y Fu	1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 🕍 No If Yes, Give		1 ☐ Yes 2 ☑		viexican, r Specify:	ruento raican, etc.)	Specify:	White, etc. White
Ö	tural'	ed by	3 Widowed 4 Divorced Year or Dates:	16a Dece	dent's Usual (Occupation	n		16b. Kind of Busin	
215	hin 72 9. 9n na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work of DO NOT use	done durii retired)	ng most o	f working	TOD. KING OF BUSIN	loss industry
21	ed wit ygiene yer tha	Com	10		Labor				Factor	Y
Maryland 21215-0036	d be til	To Be	17. Father's Name (First, Middle, Last) UnKnown			18		Name (First, Middle rv Elizab	e, Maiden Sumame) eth Mulli:	nex
ary	should nd Me mark umati	Ĕ	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (S	Street and	Number o	or Rural Route Numb	per, City or Town, Sta	
ž	and 2 salth a n 27 ls		Nancy K. Mullinex (Wife)	64 W	. Churc	ch St	t. Ha	gerstown,	Md. 21740	
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational be notified at once.		1 Burial 2 XCremation 3 Bemoval from State	cob. Place of Dispo cemetery, cre Smithsbu	matory or othe	r place)		ov. 25, 2006	20c. Location - Cit Smithsbu	•
- Balt	permit. Departimport Import any inj		21. Signature of Funeral Service Licensee		2. Name and A				2525 Brad mithsburg	bury Ave. ,Md. 21783
		J	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.			(6	arrest,	Approximate Interval Between Onset and Death
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S. Box	The law requires that the death certific sie has been signed by the attending p page 2 should be detached for use as	Physiclan/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic pregi ⊒ Other <i>(speci</i>	nancy ify)			23d. Date o Month	f delivery Day Year
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Division of	al or Atte s after dea al Directo	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - building, etc. (S	At home, farm, sti pecify)	reet, factory, or	ffice		28f. Location (City or To	(Street and Number own, State)	or Rural Route Number,
	To the Hospital or Attending Physician: The I within 2 Housra after death. To the Funeral Director: After this certificate ha completely tilled in by the tuneral director, page	Medical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of m 2 Medical Examiner: On the basis of exa	y knowledge, deat imination and/or in	h occurred at t vestigation, in	the time, o	date and p	alace, and due to the occurred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
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	P		30. Name and address of person who completed cause of death A A 1 D S 1		- 11	26	70	erstour	MD	21740
	Sta Registr		31. Date filed (Month, Day, Year) 32. Posistrar's S	July A	barle)		

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			Decedent's Name (First, Middle, La	ist)							2. Date of De				3. Time of	Death
	Physici	_	Miyoko M. Norton							1	Month Novemb	er 6	, 200	ear 6	2:33	РМ
	/Media		4a. Facility Name (If not institution, give	re street and numb	er)		4h Cily T	own or	Location o		THE VEHICLE		County of		2.55	
	Examir	er					Anna			or Dougn			ne Ar		7	
			Anne Arundel Med 5. Social Security Number 6.5			last birthday)	If Under 1	-	If Under:	24 Hrs	8. Date of Bir					
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	and		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10	d. Inside Cit	tv Limits
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7	ygier Perth	Sor		2		Home 1	Maker					Own	Home			
B	al Hy	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle,	, Maiden	Sumame)			
<u>a</u>	uld by Ment	10	Matsuji Matsumot	0					Nats	su Ma	tsumot	0				
Maryland	sho and h		19a. Informant's Name/Relationship	Туре, Print)		19b. Mailir	ng Address (Street a	nd Numbe	r or Rural	Route Number	er, City o	r Town, Sta	te, Zip (Code)	
Σ	alth a		James Robert Nor	ton/ Husl	and	4100	Cross	swic	k Tur	n Boy	wie, M	D 20	715			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural; or Items 23a. any injury or other traumatic event, It is Madical Examinat must b once.		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name	e of		Da	ite	20c. Lo	cation - Cit	y or Tow	n, State	
2	ages int of t: If i		1 A Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		ate	emetery crer Arlin tional	gton	ner piace	"	0.404	10006					
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	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on eac	h line.	S. Do not ent	er the mode	or dying	, such as	cardiac or	respiratory a	rrest,		1	Approximate Interval Bety Onset and E	ween
	/Medical Examiner		Todaling in doubly	Due to (or	as a conseq	uence of):		- 21								
		_	Sequentially list conditions,	b		41										
	sit s	dical Examiner	cause. Enter Underlying	Due to (or	as a conseq	neuce of):										
	icate be executed physician and s the burial-transit	am	Cause (Disease or injury that initiated events resulting in death) Last	c												
8760,	e exerian a	ũ	resulting in death) Last	Due to (or	as a conseq	uence of):										
376	ate b nysic he b	ica		_ d.												
			IEEE VALE												-	_
Вох	that the death certifi ed by the attending I detached for use as	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		Testania ara	~~~~				2	23d. Date of			
m.	deat e att	icia	in the past 12 pronths? 1 ☐ Yes 2 ☐ No	4☐Pregnan	t at time of d		Ectopic pred Other (spec						Month	С	ay Y	'ear
0	the sy the ache	Jys	9 Unknown	9□ Unknow	n											
ص ِ	The law requires that the death certificate has been signed by the attending sage 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions	contributing to deal	h but not res	ulting in the ui	nderlying cau	use give	n in Part I.		23e. Did to	obacco u	se centribu	ite to the	cause of de	eath?
Records,	uires signe d be										1 🗆 `	Yes 2	_No 3[Probal	bly 4 □U	inknown
Ö	w requir been s should	Completed									- 11E					
ě	e law	npi									24a. Was autop	osy	prior	r to com	sy findings a pletion of ca	ivailable luse of
	Th pag	Co		,							1 Yes	rmed2 2 No	deat	Yes 2	!□ No	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	ne)				
+	nysic is ce dire	2	1 ☐ Yes 2 ☐ ₩6	Hospital: # Inp	atient 2 🗌	ER/Outpatien	t 3 🗆 DOA	Othe	r. 4 □ Nur	rsing Hom	e 5 🗆 Resid	dence 6	Other (Specify)		
	ding Ph		27. Mannar of Death	28a. Date of	njury Day Year)	28b. Time of Injury	280	c. Injury Work	at 2		3d. Describe t					
<u>.</u>	ath. r: Afr	atio	1		Day real/	injury	М		es 2□N	No						
Division	Attending ir death. actor: After by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of	Injury - At ho	ome, farm, stro	et, factory,	office		28	3f. Location (S			r Rural i	Route Numb	per,
=	afte Dira	ert	4 Homicide	building	, etc. (Specify	y)					City or Tov	vn, State))			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a, Certifier 1 Certifying Pl	ysician: To the b	est of my kno	wledne, death	occurred at	t the time	a date and	d place an	nd due to the	Calleo(e)	and manner	r ac etal	haf	
	Fur Fur stely	Medical		niner: On the basi	s of examina	tion and/or inv	estigation, in	n my op	inion, deat	h occurred	at the time,	date and	place, and	due to t	he cause(s)	
	thin thin mple	Me	29b. Signature and little of ceptifier	and paring	Jiurod.		290	License	number			29d Date	e signed (N	fonth D	ay, Year)	
	5 ± ½ 5		110//	in alth	00.0))	742	+5		1/	100	Jany De	7/ 1/	2
,			Ch III	rollen	11/2		1/-	13	0 /	10		//	100	/ -	er t	
	y.		30. Name and press of person who	completed cause	of death (Item	23a) (Type,	Print)	1	1/7	6	1/1/		1		C10	
	0		La IV	~170/611	6	UCI	(11/1)	1/	1 Hy	16.	111	M24	2011), 1	111	
	Sta		31. Date filed (Month, Day, Year)	Reg	istrar's Signa	ture	J	/	, ,	/			-	,		
	Registr	ar	NOV 0 9 20	JUO JUO	100 100	P. Contract	455									

			For State Registrar	State of Maryland		rtment				giene Reg. No	006	38146
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last) At hy 4a. Facility Name (If not institution, give street) 8 43 Shirt	ely CT		4b. City, To	nno	cation of Death	5	04 4c. Cc	Year O6 ounty of Death	Arunda
	Funeral Director		5. Social Security Number 233-34-9958 Usual Residence of Decedent	7. Age (In yrs. las	Yrs.			lours Min.	8. Date of Bin (Month, Da July 13	y, Yea <i>r)</i> 3 1923	9. Birth Con West	place (State or Foreigh intry) Virginia
	the Maryland 28a-f ehow	ector	10a. State MD Anne Aruno 10b. Street and Number		Town or Loo napoli		ode			10a Citize	n of What Cou	10d. Inside City Limits 1 ☐ Yes 2√€No
036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Deperment of Heath and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Iteme 23e or 28e-f ehow mithortent: If Item 27 is marked other than "naturel", or Iteme 23e or 28e-f ehow appropriately from the modified at an once.	by Funeral Director	1843 Shively Court	Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ No IYes, Give X Year or Dates:	-		214 nt of Hispa Cuban, M		pecify Yes or No Rican, etc.)	- 14.	USA Race - Amer Black, White	ican Indian,
21215-0036	d within 72 ho giene. ir than "natur ibe Madical	Completed	15. Decedent's Educal (Specify only highest grade of Elementary/Secondary (0-12)		(Give I	OO NOT use	done durii	n ng most of wor	king		of Business/Ir	
Maryland	should be file nd Mental Hyg I marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) George E. Blanton					Inez				
	ages 1 end 2 st int of Health and t: If Item 27 is n y or other traun		19a. Informant's Name/Relationship (Type Vickie L. Blankinsh 20a. Method of Disposition 1 □ Burial 2 【ACremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	nip (Daughter)	184 ce of Dispos netery, crem	3 Shive	of er place)		Annapol Date	is, M	D 2140 tion - City or T	1 Town, State
Baltimore,	permit. P Departme Importan eny Injur.		21. Signature of Eunera Pervice Licens	Metr		Matory Name and Hardes 12 Ric	Address o	Facility uneral	Home, F	.A.	more,	
3760,	Physician and Inspection and Inspect	Ilcai Examiner	23a. Part1. Enter the disease, or complica shock, or heaft failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to unmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. d.	Due to (or as a conseque	ence of):	er the mode of	and dying, s	uch as cardiac	or respiratory ai	rrest,		Approximate Interval Between Onset and Death Imem
.O. Box 68	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3□	Ectopic preg Other (spec				230	I. Date of delive Month	very Day Year
rds, P	w requires that the been signed by th should be detache	ρ	Part II. Other significant conditions contri	buting to death but not result	ing in the un	derlying cau	se given ii	n Part I.	23e. Did to			the cause of death?
al Records,	> 0	Completed	Hyperte	pidemi	2_				1 Yes	rmed?	prior to co death?	opsy findings available ompletion of cause of
Division of Vital	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be	27. Manner of _eath 1 Natural	(Month, Day Year)	8b. Time of Injury	28c	Other: Injury at Work? 1 Yes	6. Place of Dea 4 Nursing H	28d. Describe h	dence 6 one of the following of the foll		
Divi	Hospital or Att 24 hours after d Funeral Direct tely filled in by I		4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify) ian: To the best of my knowledge.				date and place	City or Tov	vn, State)		al Route Number,
	To the Hos within 24 ho To the Fun completely i	Medical	29b. Signature and title of certifier	rian: 10 the best of my knowler. On the basis of examination and manner stated.	in and/or inv	estigation, in	ine time, of my opinio	on, death occur	red at the time,	date and pla	igned (Month,	to the cause(s)
_	8		30. Name and address of person who com	When cause of death (Item 2	23a) (Type, I	Fint)	5	Ann	apol	es 1	uD:	21401
	Sta Registr	-	31. Date filed (Many) Day, Jean 2006	Registrar's Signatu	re	A.						

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 1 Hh 2000 ARKAR NOVEMBER ARTHA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner NNEI TRUNDAL SSIFTED LIVING 1 Year If Under 24 Hrs. INRISE 8. Date of Birth (Month, Day, Year) Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 ☐ M 2 🔀 F Days Min. 89 Director 427-01-2544 February 18, 1917 Mississippi Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 23a or 28a-f ehow the Medical Examiner must be notified at Maryland Anne Arundel Annapolis 1xxxYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Bestgate Road 21401 USA death Funerai iteme 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☐ ¥No Specify þ 3 ☑ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed wir Department of Health and Mental Hygient Importent: if Item 27 is marked other tha eny injury or other treumetic event, Imal 2002. Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Iva Lamar Dorroh Bessie Greer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Alan Parker - Son 222 Lookout Lane, Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 DBurial 2 □ Cremation 3 □ Removal from State Hillcrest Cemetery 11-17-2006 Annapolis, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or emplications the dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DVANCED DOMENTIA ZYEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed -leurial-Due to (or as a consequence of) Box 68760. Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 19 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 🗆 Yes Be 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: 1 Inpatient 1 🗌 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Wither (Specify) ASSISTED 2 2 ER/Outpatient 3□ DOA this 27. Mann of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 A atural 5 Pending death. i Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D96360 30. Name an 8601 VOTORNSHIGHWAY MILLORSVILLE MD 21108 completed cause of death (Item 23a) (Type, Print) address of person who 31. Date filed (Month, Day, Year) State 2006 NOV 15 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] 5 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Erminia Olga Padua а м November 14. 2006 1:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Manor Care-Potomac Potomac If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🝊 F 84 Yrs. 578-52-6566 May 13, 1922 Italy Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits ahow 10b. County r than "natural, or Itams 23a or 28a-f ahov tre Medical Examinar nast be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 5 Dairyfield Court 20852 Italv Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Timore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Clothing Seamstress permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 Is marked other any injury or other traumetic. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Angelina Villanti Francesco Repici 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosanna M. Klein/ Daughter 5 Dairyfield Court, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 18 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 50 Other (Specify Emtombment Gate of Heaven Cemetery 2006 Silver Spring, Maryland 21. Signatur on Funeral Service Licenses Francis Adress Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive heart failure /Medical Due to (or as a consequence of): **Examiner** AGRIC STE NOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and the for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed 1 Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 KNo 1 Inpatient 2 ER/Outpatient 3 DOA e Hospital or Attending Phys 24 hours after death. a Funeral Diractor: After this stely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1255

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

2. Registrar's Signature

Suni tha Bhogawilli

31. Date filed (Month, Day, Year)

1220 A East Toppa Road sceen 230 TOCO SON 4021286

2005 A 166

11/14/06

		-	For Stete Registrar		State	of Maryla	and / Dep <i>Ce</i>	artmer rtificat				-	giene Reg. No	UUD	38149	
	Dhamini		1. Decedent's Name (Firs	t, Middle, La	ist)							2. Date of De	aath Da	v Yea	3. Time of Death	
	Physicia /Medic		Nadire Pra	ett P	eer							11	17		1:05 P M	_
	Examin		4a. Facility Name (If not it	. 5				4b. City,	Town, or	Location	of Death			. County of De	eath	
			The Pine						ston 1 Year	If Under	24 Hrs	Data of Riv		albot	(0)	_
	Funeral Director		 Social Security Number 220-14-0562 		Sex 1 □ M 2 □ XF	7. Age (in y.	rs. <i>last birthday</i> Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da July 4,	y, Year)	75	inthplace (State or Foreign Country) MD	J
			Usual Residence of Dece					<u> </u>				jung 1				
	nyland how	. [County			City, Town or L enton	ocation							10d. Inside City Limits	
	Ba-1 s	cto	MD Ca	rolin	e 		2111011					 			1 ☐ Yes 2 ☐ No	
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, the Medical Eco. direct most be notified at	ai Director	10e. Street and Number 25766 Beau	ıchamp	Branch	Road		10f. Zip	Code	2162	9	ı	-	tizen of What (SA	Country?	
	ems er na	by Funerai	11. Marital Status	-	12. Was Dec	edent Ever in	U.S. 13.	Was Dece	dent of Hi	ispanic Ori in, Mexicar	igin? (Spe	ecify Yes or No Rican, etc.)	0-	14. Race - An Black, Wh	nerican Indian, nite, etc.	
36	or It	y Fu	1 Never Married		1 ☐ Yes If Yes, G	2 ⊅ No ive		1 🗆 Yes		Specify:				vacetor u		
Ö	hour:		3 ☐ Widowed 4 ☐ I		Year or I	Dates:	162 Doc	edent's Usu	al Occupi	ation				(ind of Busines		_
7	n 72 "na" n	Completed	(Specify on		ade completed		(Give	kind of wo	ork done d se retired	during mos	t of worki	ng	100. 1	and or busines	as inclusing	
212	filed within Hygiene. Other then "	mo	Elementary/Secondary	(0-12)	College	(1-4or 5+)		emake					Fan	nily		
b	il Hygi other	a	17. Father's Name (First,	Middle, Las								(First, Middle				
<u>Jar</u>	should be ind Mental i marked o	To B	Freeman		Pasca	l				Mat	tie		l	Vall		
Maryland 21215-0036	2 should be and Mental Is marked o		19a. Informant's Name/F			,								or Town, State		
	1 and Health tem 27 other tr	-	Nancy Van		/ daugh		20 / D. Place of Disp			מ קאוני		ate		ton, MD		_
ŏ	it of h		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cre	mation 3 (☐Removal from	State	cemetery, cre	amatory or o	other plac							
Baltimore,	it. Pa intmer intent njury		'4 □ Donation '5 □ 21. Sign ture if Funeral				apitol	2. Name a		1	1/19	700	DOL	ver, DE		
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		Kand	pu	1 Nour		M	oore	Fune	ral H	lome,			2nd St.	Denton, MD 21620	
			23a. Part1. Enter the dis shock, or heart fail	ease, or cor uré. List onl	nplications that one cause on	caused the deach line.	eath. Do not er	nter the mod	de of dyin	g, such as	cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death	
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	/Medical Examiner		resulting in death)		Due to	(or as a cons	segueno of):		/						1	
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Ć,	te be executed ysician and te burial-transit	Examine	that initiated events resulting in death) Last		c. Due to	(or as a cons	sequence of):								1	-
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Box	eath certific attending p	hysiclan/Me	23b. Was decedent preg		1 ☐ Live	utcome of pre birth 2 P	etal death 3	□Ectopic p	regnancy					23d. Date of d	lelivery Day Year	
0. E	at the dea by the at tached fo	/sicl	in the past 12 plont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Preg 9⊟Unk	nant at time o	of death 5	Other (s)	pecity)					Wilding	Juy July	
Ρ.	that the ed by detacl	۵.	Part II, Other significant	conditions	contributing to	death but not	resulting in the	underlyina (cause div	en in Part I	l.	23e. Did	tobacco	use contribute	to the cause of death?	
rds,	w requires that the been signed by th should be detache	ed by						, ,				1 🗆	Yes 2	□No 3□	Probably 4 Unknown	
Record	s b	ompleted										24a. Was		prior to	autopsy findings available o completion of cause of	,
E .	The l	Con										perfe 1 Yes	ormed? 201 No	death′ 1 ☐ Ye	? as 2□No	
Vital	icien: Th certificate rector, pag	Be	25. Was case referred to examiner?	medical	Hoositals &	2			04		e of Death	(Check only	one)			
of \	Phys this al dir	2	1 Yes 2 No				28b. Time		-	4 LJ NI		me 5 Res 28d. Describe		6 Other (Sp	pecify)	-
	ing After une	ion		Pending investigation		of Injury nth, Day Year) Injury	M M	28c. Injun Worl	yal k? Yes 2□		zod. Describe	now inju	ny occurred		
Division	of or Attending after death. I Director: After d in by the fune	fica		Could not determine	be 28e. Plac	e of Injury - A	t home, farm, s				_	28f. Location (Street a	nd Number or i	Rural Route Number,	-
Ö	- e -	Certification;	4 Homicide	determine	u buil	ding, etc. (Sp	ecify)					City or To	wn, Stati	9)		
	To the Hospitel of within 24 hours af To the Funeral D completely filled it	edical (as stated. ue to the cause(s)	_
	To the To the comp	M	29b. Signature and title	of certifier	Wim	81		29	c. Licens	e number	100	33	29d. Da	ite signed (Mo.	nth, Day, Year)	
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			30. Name and address of	100	With	use of death (tem 23a) (Type	Print)	Ens.	Lan	0, 6	Easto	ا رس	MD 2	21601	
	Sta Registi		31. Date filed (Month, D	ay. Year)		Registrar's Si		All a	,		-					
	- riegisti				1	THE WAR ST.	J. ANDER	W.A. F								

			_ For	State of Maryla	nd / Dep	artment of h	Health a	and Me	ental Hy	/gien	ne	
			1 - State Registrar		Ce	rtificate of	Death			Reg. N	10.200E	38150
, the	Physici	an	Decedent's Name (First, Middle, Last						Date of De Month	eath D	av Year	3. Time of Death
	/Medic			is Quillen,	Sr.				10/EW		18, 20	
)	Examin	er	4a. Facility Name (If not institution, give Saint Joseph		enter	4b. City, Town, o	T	OWS	מז כ	4	lc. County of Dea Ba	ltimore
) i	Funeral		5. Social Security Number 6. Se	AM 2DF	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2	Min.	8. Date of Bit (Month, Da	<i>ay, Y</i> ea	ir) [C	thplace (State or Foreign ountry)
	Director		221 - 20 - 0419 Supplemental Su	7	4 115.				January	24,	1932 Ma	ryland
	/land		10a. State 10b. County	10c. (City, Town or Le	ocation						10d. Inside City Limits
	Man a-f sh	혅	Maryland Carolin	re	Dente	n						1 ☐Yes 2 ☐ No
	or 28.	Director	10e. Street and Number			10f. Zip Code				10g. C	Citizen of What C	ountry?
	ath w		127 Butler Drive			21629					ted Sta	tes of Ameri
	er de	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Orig an, Mexican	gin? (Spec n, Puerto R	ify Yes or No ican, etc.)	0-	14. Race - Am Black, Whi	
36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Von Chia		1 ☐ Yes 2 ☑ No	Specify:				Specify: Cau	log tian
5-0036	be filed within 72 hours after death with the Maryland the Vigiene. bd other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	bed	15. Decedent's Edu	ıcation	16a. Dece	dent's Usual Occup	pation			16b.	Kind of Business	/Industry
215	e. an "n Medi	ple	(Specify only highest grad	College (1-4or 5+)		kind of work done DO NOT use retire	•	t of workin	g	Ra	Inidaan	ut ion
2	ed wil ygien ier th	Completed	11 HS Grad			self empl	1			1		rtion Service
nd	be deve	Be	17. Father's Name (First, Middle, Last)				Ĭ			, Maide	en Surname)	
Maryland	should be ad Menta marked matic ev	၉	19a. Informant's Name/Relationship (Ty	ayton Quiller		4-11 (011					Rogers	
<u>ā</u>	d 2 sl th an th an traur		Lois 4. Quillen	Wife	1	ng Address (Street Butler Dr						
ā,	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		20a. Method of Disposition			osition (Name of matory or other pla		Denco		~	Location - City or	
Baltimore,	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State		matory or other pla Lemetery		1/25/	2006	חם	nton, Mo	unuland
≣ a	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licens		2	2. Name and Addre	ess of Facility	v				
m	De lun	il i	Vaucobili	Mode	- 70	302e Fune South S	ral Ho econd	ome, Stre	P.A. et. De	ento	п. Малия	and 21629
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the de ne cause on each line.	ath. Do not en	ter the mode of dyli	ng, such as	cardiac or	respiratory a	rrest,	, ,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CORONARY	ARTE	RY DISE	ASE					Onset and Death YEARS
	/Medical Examiner		resulting in death)	Due to (or as a cons		/TT 15 / T / C						
		į.	Sequentially list conditions,	b. CARDIAC Due to (or as a conse		AIHMTH						30 MINUTES
	uted 1	Examiner	if any, leading to infriediate cause. Enter Underlying Cause (Disease or injury that initiated events									
ó	exection and and rial-tra	Еха	resulting in death) Last	Due to (or as a cons	equence of):							
8760	cate be executed physician and the burial-transit	dical		d							···	
		Med	IF FEMALE:		_							
Вох	The law requires that the death certific to has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe	etal death 3	Ectopic pregnanc	у				23d. Date of de Month	livery Day Year
	at the de by the a stached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	f death 5[Other (specify) _					World	buy rear
٦.	that t ed by detac	/ Ph	Part II. Other significant conditions co	ntributing to death but not r	esulting in the u	nderlying cause giv	ven in Part I.		23e. Did t	tobacco	use contribute t	the cause of death?
rds	w requires that been signed k should be det	d by							10	Yes	2 X No 3 □ P	robably 4 Unknown
Records,	s beel	Completed							24a. Was	an	24b. Were a	utopsy findings available
Ä	The law cate has I page 2 s	mo								ormed?	death?	utopsy findings available completion of cause of
Vita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place	of Death	│ 1□ Yes 'Check only o	2 💹 N one)	10 1 11195	2 □ No
<u>-</u>	Physic this ce al direc	To E	examiner? 1 ☐ Yes 2[X]No	Hospital: 1 ☐ Inpatient 2	▼ ER/Outpatie	nt 3□ DOA Oth	OF:				6 □Other (Spe	cify)
_ _	ing Pt Viter th		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	ry at rk?	28	d. Describe	how inj	ury occurred	
210	ttend leath. tor: / the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	On Dissertision A	h (Yes 2□N					
Division or	after death after death I Director:	Certification:	4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spe	cify)	eet, factory, office		28	City or To	Street a wn, Sta	and Number or R ite)	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	Medical C	29a. Certifier 1 X Certifying Phy (Check only one) 2	sician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at the tivestigation, in my o	me, date and opinion, deat	d place, ar th occurre	nd due to the d at the time,	cause((s) and manner a nd place, and du	s stated. e to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier			29c. Licens	se number			29d. D	ate signed (Mon	h, Day, Year)
)			Jane P. Cu	mym		D	39215	ō		11	118/00	
			30. Name and address of person who co	ompleted cause of death (It	em 23a) (Type,	Print)	-				, , , , , ,	·
			GAIL P. CUNNII	NGHAM, M.D.	760	1 OSLER	DRIV	E,	rowsor	N.	MARYLA	ND 21204

Registrar

NOV 2 1

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	Physici		Decedent's Name (First, Middle, Las Rose	nindler					2. Date of Dea Month Nov. 10	Day	3. Time of Death 8:10 P. M
	/Medic Examir		4a. Facility Name (If not institution, give Potomac — Manor Ca	street and number)		4b. City,	Town, or Lo	ocation of Dea		4c. County	
	- Funeral Director			7. Ag	e (In yrs. last birthday 94 Yrs.) If Under Months		f Under 24 Hrs Hours Min		Year) 1912	9. Birthplace (State or Foreign Country) Massachusetts
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County MD Montgomer	У	10c. City, Town or L Potomac	.ocation					10d. Inside City Limits 1 ☐ Yes 2 No
	with the	I Direc	10e. Street and Number 9117 Fa 9117 Falls River	ll River I Lane	Lane	10f. Zip	Code 20854			log. Citizen of V U.S	
980	be filed within 72 hours after death with the Maryland hal Hygiene. Id other then "naturel; or iteme 23e or 28e-f ehow event, the Medical Exeminational be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☒️ If Yes, Give Year or Dates:		Was Deced If Yes, spec	ify Cuban,	anic Origin? (S Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Blac	ce - American Indian, ck, White, etc. y: White
21215-0036	within 72 h jene. r then "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5 4	(Giv	edent's Usua e kind of wor DO NOT us ntant	k done dun	on ing most of wo	rking	16b. Kind of B	usiness/Industry ting
Maryland 2	12 should be filed within and Mental Hygiene. Fis marked other then "raumatic event, Ita Me.	To Be C	17. Father's Name (First, Middle, Last) Kelman Hirsh	field			18		me (First, Middle, erman	Maiden Suman	ne)
	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (7 David Rindler / s		19b. Mail 9117	ing Address	(Street and → Rive	NumberorR er Lå.,	Potomac	, City or Town, MD 20	State, Zip Code) 854
Baltimore,	permit. Pages 1 and 2 Depertment of Health : Important: if item 27 i eny injury or other tra once.		20a. Method of Disposition 1 🛣 Burial 2 🗆 Cremation 3 🗆 4 🗆 Donation 5 🔎 Other (Specify		20b. Place of Disp cometery, cre Menorah	matory or of	ther place)	Nov.	Date 14,2006		City or Town, State
Balt	permit. Pages Depertment of important: if i eny injury or once.		21. Signature of Final Sequice Lipen	36	rchinsky	Hebrew nington	Funeral Home				
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused ine cause on each lin	the death. Do not er	nter the mode	e of dying, s	such as cardia			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	7 17 2			.,		
8760,	cate be executed physicien and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as c	a consequence of):						
	The law requires that the death certificat te has been signed by the attending phy bege 2 should be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pre				1	te of delivery inth Day Year
rds, P.	w requires that been signed t should be det	þ	Part II. Other significant conditions or	ontributing to death bu	ut not resulting in the	underlying ca	ause given i	in Part I.			ribute to the cause of death? 3 ☐ Probably 4 ∰Unknown
		Completed							24a. Was a autops perform	ned?	Were autopsy findings available prior to completion of cause of death? □ Yes 2⊠ No
Vita	8 8	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:			Other		ath Check only on		
C = E = C T Matural 5 □ Pending 26. Month, Day Year) C Month, Day Year) C									10me 5 Residence 28d. Describe ho		
******	- 9	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ury - At home, farm, si c. (Specify)	reet, factory,	, office		28f. Location (Si City or Town	reet and Numb n, State)	er or Rural Route Number,
	To the Hospital of within 24 hours at To the Funerel D cumpletely filled in	Medical	29a. Certifier (Check only one) 1. Certifying Phy 2 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	of my knowledge, dea examination and/or ii ited.	th occurred a nvestigation,	at the time, in my opini	date and place on, death occu	e, and due to the curred at the time, d	ause(s) and ma ate and place, a	anner as stated. and due to the cause(s)
	viithir To th	Ž	29b. Signature and title of certifier	w			License ni	umber 54.56			d (Month, Day, Year)
	4		30. Name and address of person who c			, Print)				11/13/0	
	Sta	te.	31. Date filed (Month, Day, Year) NOV 15 20	1210 32 Megistra	A East Tar's Signature	offa	Rocc	1, Sw	h 2 50 7	Resolution	Mn21286
	Registr		NOV 1 5 20	306	J. B. A.	SHEL					

			1 - For State Registrar	State of	Maryland		artmen rtificate			and Me		giene	411115	381	52
	Physici	an	1. Decedent's Name (First, Middle, L	.ast)						1	2. Date of De Month	ath Day	Year	3. Time of Do	eath
	/Medic		Eleanor M.	Rouse									, 2006	11:45	A M
1	Examin	er	4a. Facility Name (If not institution, g		oer)				Location o				County of Dea		
			4809 Preston 5. Social Security Number 6.		. Age (In yrs. I	act hirthdayl	F e		alsb:		B. Date of Bir		Caroli		
	Funeral Director		080-24-6640	1□M 2/□F	. Age (in yrs. i		Months	Days	Hours	Min.	Month, Da	iy, Year)	9. Bir	thplace (State or F buntry) V York	-oreign
			Usual Residence of Decedent			1			ll		JCC. 2	, 10.	Z9 Nev	VIOIK	
	how		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City	Limits
	e Ma	cto	MD Carol	ine		Fede	rals	burg	g					1 □ Yes 2	¥ No
	ih th	Directo	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What Co	ountry?	
	23e	ra	4809 Preston						532				ed St		
	at de de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede	es?	S. 13.	Was Deced If Yes, spec	fent of Hi of Cuba	ispanic Origin, Mexican	gin? (Spec n, Puerto R	ify Yes or No ican, etc.))-	 Race - Ame Black, White 		
38	urs af	by F	3 ☑ Widowed 4 □ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date	S:		1□ Yes	X □ No	Specify:				Specify: W	hite	
ŏ	within 72 hours after death with the Maryland iene. than "neturel", or iteme 23a or 28e-f ehow the Madical Exeminer must be maillied at	ted	15. Decedent's			16a. Dece	dent's Usua	l Occupa	ation			16b. Ki	nd of Business		
2	thin 7	op le	(Specify only highest g Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT us	nk done d se retired	during most)	t or working	3	R10	ick &	D = 0 1r = m	
2	filed wi Hygien other th	Completed	11			Asse	mb1y	Woı						Decker	
<u>n</u>	be fill d oth	Be	17. Father's Name (First, Middle, La.								First, Middle,		Sumame)		
<u> </u>	should and Men amarke umaric	ဥ	Walter E. Lan								. Lit				
a N	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural; or Iteme 23a or 28e-f show appring to other traumatic event, the Madical Extending must be notified at once.	1 3	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a	and Numbe	eror Rumal.	Route Numb	er, City o	r Town, State,	Zip Code) 216	31
ė,	Healthern		Sandra Bilbron 20a. Method of Disposition	ıgh/Daug	20b. PI	lace of Dispo	sition (Nan	ne of		E KO a			New Ma	arket,	MD
nor	ages int of t: if it		1 Burial 2 ☐ Cremation 3 4 Donation 5 ☐ Other (Spec	☐Removal from St	ate Cé	emetery, crer	natory or or	ther plac						Marylan	. al
Baltimore, Maryland 21215-0036	artme ortani		21. Signature of Funeral Service Lic	***	Las										
Ba	permit. P Departm Importat eny injur		Michael 7	- Eskor	U	410	7 14 • 1	татп	JL.,	rede	raisbu	ırg,	eral 1 MD 2163	Home, P 32	. A .
			23a. Part1. Enter the disease, or co shock, or heart failure. List on tmmediate Cause (Final	mplications that cau ty one cause on eac	ch line.			e of dyin	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Betwe Onset and De	en eath
1	Physician /Medical		disease or condition resulting in death)	a		nem	a	0/	10	noi	l_			- 2 yes	ars
Н	Examiner	1		Due to (or	r a <i>s</i> a consequ	ierice oi):		U						· ·	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	r as a consequ	uence of):									
	nd nd transi	Examiner	that initiated events	c											
ဂ္က	be executed sician and burial-transit	EX	resulting in death) Last	Due to (or	r as a consequ	ence of):									
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× 6	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outco	ome of pregna	ncv									
Вох	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birt	h 2 Fetal	death 3	Ectopic pro					2	23d. Date of del Month	Day Yea	ar
o.	the d ny the ached	lsk	1 ☐ Yes 2 🗹 No 9 ☐ Unknown	9□ Unknow											
٠ <u>.</u>	res thet the de signed by the a l be detached f	by Pł	Part II. Other significant conditions	contributing to dea	th but not resu	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did t	obacco u	se contribute to	the cause of dea	ath?
ğ	w require been sig should b	pa pa									10	Yes 2[I No 3 □ Pr	obably 4 Uni	known
O O	awre is bee 2 sho	Completed									24a. Was		24b. Were at	utopsy findings ava	ailable
ž	The I	E										omed?	death?	completion of cau: 2 No	se of
<u>ta</u>	Attending Physicien: The lav r death. sctor: After this certificete hes by the funeral director, page 2	Bec	25. Was case referred to medical examiner?						26. Place	of Death (Check only o		10100	2010	
<u>></u>	hysic his ce I dire	To I	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp	patient 2 🗆 I	ER/Outpatien	nt 3 DO	Othe	er: 4 □ Nui	rsing Hom	e 5 Resid	dence 6	6 ☐Other (Spe	cify)	
בֻ	tending Ph leath. lor: After th the funeral	ü	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	2	8c. Injury Work	at	28	d. Describe l	how injury	y occurred		
<u>s</u>	Mtendi death ctor: A	catl	2 Accident investigat 3 Suicide 6 Could not	he			М		Yes 2 1		_				
Division of Vital Records,	or At after Direct Direct Direct	Certification;	4 Homicide determine	28e. Place of	f Injury - At ho j, etc. <i>(Specif</i> y	me, farm, str	eet, factory	, office		28	If. Location (: City or To	Street and wn, State)	d Number or Ri)	ural Route Numbe	ar,
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying 2 Medical Ex	Physician: To the bas	is of examinat	wledge, death ion and/or in-	occurred a	at the tim	ne, date and pinion, deat	d place, an	d due to the	cause(s) date and	and manner as place, and due	s stated. to the cause(s)	
	To the Ho within 24 To the Fu completel	Mec	29b. Signature and title of certifier	and manne	stateu.				number				e signed (Mont		
	⊢≯⊢ŏ		1 Anna	Kloro	de	20			135	7			20-20		
			30. Name and address of person wh	o completed cause	of death (Item	23a) (Type		1 1		-		• • •			
			8221 Teal	Dr.		te 20	4 "	E	asta	m,	MD	2	1601		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signat	ture	inde								

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day, Year **Physician** 5:30 PM JEORGIA 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges 76 If Under 1 Year If Under 24 Hrs. HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1□M 200 F 500 Yrs. Director 226-68-6185 12-22-46 ACKANSAS Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examinar intel by notified at 1 Yes 2 No WASHINGTON \supset C10e. Street and Number 10g. Citizen of What Country? Burroughs U.S.A NE 5000 NANNIE Heles 20019 12. Was Decedent Ever in U.S. Armed Frees?

1 Yes 2 No ff Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1□ Yes 2▼No Specify: Slack ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Hanensker Danestic 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Kowe Lucada 19a. Informant's Name/Relat Inship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Health item 27 i 1DAVahter Marbrook Lane Kowe 996 York 17404 Date 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite any injury or ot once. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/21/06 Riverdale Park Crem 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Williams 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ArdiAc Archythia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner tailure RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) transit requires that the death certificate be executed Due to (or a a consequence of): ettending physicien and for use as the burial-tran resulting in death) Last burial-t Physician/Medical as the IF FEMALE: esn nse 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e P.0. 9 Unknown been signed by should be detect Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š Accident erebrovascular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed therosclerosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 No this certificete 1 ☐ Yes Division of Vital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospitaf: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the majorus efter death.
To the Funers! Director: After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) 22435 30. Name and a press of person who completed cause of death (nem 23a) (Type, Print) 11120 New Hamp Are, 5:408 S.S. MD. 20904 Trazier 32. Registrate Signature 31. Date filed (Month, Day, Year) State Claries -NOV 3 0 2006 Registrar

			1 - For State Registrar Amend #19a	State of Ma						ınd M		giene Reg. No.	006	38154
	District 1		1. Decedent's Name (First, Middle, Last)			M 11-7	27-20	00		T	2. Date of Dea		Year	3. Time of Death
	Physici: /Medic		Doris Lar	ue Savag	e 						Novembe	er 16	, 200	
	Examin	er	4a. Facility Name (If not institution, give s 3701 Green Valle					Town, or imsvi	Location o	f Death			county of Dea	
ı	Funeral Director		219-20-1720	V -	(In yrs. la	st birthday) Yrs.	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Oct. 2:	Year)	9. Bi	nthplace (State or Foreign ountry) aryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	Mary First	tor	Maryland Frederic	k]	Ljamsv	ille							1X Yes 2 □ No
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "neturel", or iteme 23e or 28e-f ehow event, i're Medical Evertiner must be traitified at	al Director	10e. Street and Number 3701 Green Valle	y Road			10f. Zip	Code 217	754				en of What C	ountry?
	iter deat	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 □ Yes 2 □ N		i i		37		gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)	1.	4. Race - Am Black, Wh	erican Indian, ite, etc.
900	hours a	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		10 0	1 □ Yes	10	Specify:				Specify: W	
21215-0036	ithin 72 ne. Medica	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		+)		kind of woi DO NOT us make1	rk done d se retired,	uring most	of workir	ng		d of Business	singustry
121	filed with Hygiene. other ther		17. Father's Name (First, Middle, Last)	<u> </u>		Home	illakei		18. Mothe	r's Name	(First, Middle,			
Maryland	should be filed within of Mental Hygiene. i marked other then amatic event, tre M	To Be	Hubert deBruyn						Ne	llie	Eliza	beth	Cash	
	od 2 stranger tranger		19a. Informant's Name/Relationship (Type)		:	19b. Mailin	g Address Gree	en Va	nd Numbe alley	Roac Roac	i Route Numbe 1, Ija:	r, City or msvi.	Town, State, 11e, M	aryland 21754
Baltimore,	ages 1 an nt of Heal : If Item 2		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	emoval from State	Cei	metery, cren	natory or o	ther place			ate		•	r Town, State
altin	permit. Pages Department of I importent: If its any injury or of		4 ☐ Donation 5 ☐ Other (Specify) 21. Signa ure of Fyneral Service Licens	996	1 20.	Peter					P.A.,			m, Maryland
Ã	Depa Impo any is		Hovert L.	Jillia	ms	26	6401	Ridge	e_Roa	d, Da	amascus	, Ma:	ral но ryland	me 20872
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	cations that caused ne cause on each line	the death.	_		1			r respiratory are		1	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a	conseque		eou	Ca	was	COVI	WXCOXA	r Cll	<u>alano</u>	
	ped list	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseque	ence of):				5-0				
,092	ate be executed hysicien and the burial-transit		that initiated events resulting in death) Last	Due to (or as a	a conseque	ence of):								
687	tificate to paysing physical	dical												
.O. Box (death cer e ettendir id for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes → □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 1 4 ☐ Pregnant at 1 9 ☐ Unknown	2 🗌 Fetal (death 3	Ectopic pr Other (sp					20	3d. Date of de Month	elivery Day Year
Ω.	s that i	by Ph	Part II. Other significant conditions con	ntributing to death bu	ıt not resul	Iting in the ur	nderlying c	ause give	n in Part I.		23e. Did to	bacco us	e contribute	to the cause of death?
rds	w requires been sign should be		Chrone offst	welve/	2116	mone	aryc	dle	ease	-	1 🗆 Y	es 🕺	No 3□P	Probably 4 Unknown
Records,	e lay	Completed	Severe Oste	arken	ly	· · · · · · · · · · · · · · · · · · ·					24a. Was a autop perfor 1 Yes	sy megl?	24b. Were a prior to death?	
Vital		BeC	25. Was case referred to medical examiner?							of Death	Check only or			
of V	× × 5	۴	1 ☐ Yes 259 No			R/Outpatien 28b. Time of			4 140		ne 5 Resid			ecify)
ion	ding After fune	27. Manner of eath 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No									od. Describe II	ow injury	occurred	
Division	al or Attendi s efter death. I Director; A id in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	iry - At hor c, (Specify)	me, farm, str	eet, factory	y, office		2	28f. Location (S City or Tow	itreet and n, State)	Number or F	Rural Route Number,
	To the Hospital or Attan within 24 hours effer deatl To the Funeral Director; completely filled in by the	edical (29a. Certifier Certifying Phy (Check only 2 Medical Exemi	sician: To the best oner: On the basis of and manner sta	examinati	vledge, death on and/or in	n occurred vestigation	at the tim	e, date an	d place, a	and due to the dead at the time, d	cause(s) a date and p	and manner a place, and du	is stated. e to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	M	111	4	290	. License	number	C		-0		oth, Dey, Year)
			11/1/2 76	floorte	M	12/1	1	کرد	5/	83	1	or	mpen	16,2006
	5		30. Name and address of person who	suppleted cause of de	eath (Item	23a) (Type,	Print)	VOS	4	The	stra	J, 4	Trade	16, 2006 Prick, MD
ı	Sta Regist		31. Date filed (Month, Day, Year)	006 32. P sistra	ar's Signati	de de	borte	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo O O C

		•	1 - For State Registrar	State of Ma	ii yiana	Cer	tificat	e of Deat	th		Reg. No		381	55
	Physici		1. Decedente Name (First, Middle, La	m bert	St	even	S			2. Date of De Month Novemb	Da	ay Year 14, 2006	3. Time of 6:45	Death A M
1	/Medio Examin		4a. Facility Name (If not institution, giv Glade Valley Nurs				4b. City,	Town, or Location			40	c. County of Death	-	
ñ	Funeral Director		5. Social Security Number 6. S		(In yrs. las		If Under Months		der 24 Hrs.	8. Date of Bir (Month, Da Nov • 2	1	Frederick 9. Birthy Cow 936 Mar	olace (State o	r Foreign
	aryland •how	1	Usual Residence of Decedent 10a. State 10b. County	,		Town or Lo							10d. Inside Ci	
	with the M a or 28a-f Le notifie	Directo	Maryland Frederi 10e. Street and Number 56 West Frederic		wall	kersv	10f. Zip	Code 1793			10g. C	itizen of What Cou	ntry?	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other than "naturel", or Items 23s or 28s-f show sumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 24 N If Yes, Give Year or Dates:			Vas Deced Yes, spec	dent of Hispanic city Cuban, Mexi		ecify Yes or No Rican, etc.))+	14. Race - Americ Black, White, Specify: Whi	can Indian, etc.	
21215-0036	within 72 ho ene. then "netur he Medical	Completed by	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5-	+)	16a. Deced (Give l		al Occupation rk done during rr se retired) maker	nost of work	ing	16b. F	(ind of Business/In		
Maryland 2	d a b	To Be Co	17. Father's Name (First, Middle, Last, Arthur Hench Lamb					18. M o		e (First, Middle, Elizabet		n Surname)		
	and 2 shoulalth and Malth		19a. Informant's Name/Relationship (ī			y Drive				or Town, State, Zip	Code)	
Baltimore,	permit. Pages 1 and 2 should Depertment of Health and Men Important: If Item 27 le marke eny injury or other traumatic once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			ce of Dispos netery, crem Olive		me of other place) metery	!)/06		derick,		nd
Bai	permit. Page Depertment of Important: If eny injury of once.		21. Signature of Funeral Service Licer	1 TH		12	201 N	ORTH MAI	RKET S	ST., FRI	EDER	L HOMES,	21701	
)	Physician /Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each line a	Dne	eun			as cardiac	or respiratory a	rrest,		Approximate Interval Betwoen Sonset and C	ween
	Examiner up up up up up up up up up up up up up	Examiner	Sequentially list conditions, 1 a.y. leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	i ponseciual	nca uf):								
68760,	tificate be executed g physician and as the burial-transit	edical Ex	resulting in death) Last	Due to (or as a	i conseque	nce of):								
O. Box	The law requires that the death certif ite hes been signed by the ettending rage 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 Fetal de	eath 3 🗌	Ectopic pr Other (sp		4-			23d. Date of deliver		/ear
2	w requires that been signed b should be deta	þ	Part II. Other significant conditions of			_	derlying c	ause given in Pa	urt I.		obacco Yes 2	use contribute to the	ne cause of d	
Vital Records,		Completed	- Hyporton+	ion,						24a. Was autor perfo		death?	mpletion of ca	available ause of
	Physician: r this certific ral director.	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatien	, o cr	VOutpatient	20.00	Othor		Check only o		. □		
ion of	T - 5	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	/ 2	8b. Time of Injury		8c. Injury at Work?		28d. Describe I	-	6 □Other (Specifing occurred	y)	
Division	Hospital or Attending 24 hours after death. Funerel Director: Aftei itely filled in by the fune	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ry - At hom-	e, farm, stre	et, factory	r, office		28f. Location (3 City or Tox		nd Number or Rura e)	I Route Numi	ber,
	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	29a. Certifier Certifying Ph (Check one) 2 Medical Exar	nysician: To the best of niner: On the basis of and manner stat	examination	edge, death n and/or inv	occurred restigation	at the time, date, in my opinion, o	and place, death occurr	and due to the red at the time,	cause(s date an	s) and manner as s d place, and due to	tated. the cause(s))
)	To the within 2 To the comple	Σ	29b. Signatule and little of certifier				290	: License numbe		1		ate signed (Month,	*	
	6		30. Name and address of person who		71		Print)	1	70			2170.		
	Sta Registr		31. Date filed (Month, Day, Year)	2006 32. P gistra	s Signatur	k A	meli	,	POR	n. 015	NY	alto.		

RUTH STEVENS

	_ FOF	partment of Health and Mental Hyg ertificate of Death	giene 2006 38156
	Decedent's Name (First, Middle, Last)	2. Date of Dea	th 3. Time of Death
Physiciar /Medica	Elizabeth Viruinia Schrover	November	13, 2006 11:15 p.mM
Examine		4b. City, Town, or Location of Death Frederick	4c. County of Death Frederick
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		9. Birthplace (State or Foreign
Director	219-34-7425 1 M 2 XF 88 Yrs.	Months Days Hours Min. (Month, Day Septembe	r 19,1918 Maryland
DC >	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or	Logation	10d. Inside City Limits
aryta shov	M 1 1 D 1 1 1		1 ★ Yes 2 No
vith the Ma	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
with a or	117 Frederick Avenue	21701	USA
r itema 23s	11. Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Specify Yes or No-	
be filed within 72 hours after death with the Maryland last hygiene. Id other than "natural", or itema 23a or 28a-1 show event, the Medical Examinar must be notified at	If Yes, Give	If Yes, specify Cuban, Mexican, Puèrto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:	Black, White, etc. Specify: White
hours		and and a library Consenses	
n 72 n an	(Specify only highest grade completed) (G	cedent's Usual Occupation ve kind of work done during most of working b. DO NOT use retired)	16b. Kind of Business/Industry
withi iene. then	Elementary/Secondary (0-12) College (1-4or 5+) Home	maker	own home
ent,	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	
2 should be filed within and Mental Hygiene. is marked other than eumatic event, tra M	Harry Loyd Schroyer	Cora Rebecca	Green
	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Number or Rural Route Numbe 1 Raleigh Road, Walkersvil	
1 and 1 and Health em 27 ther tr		sposition (Name of Date	20c. Location · City or Town, State
Pages nent of thint: if its	1 ⊠ Burial 2 □ Cremation 3 □ Removal from State M+ Hope	rematory or other place)	Woodsboro, Maryland
ntme njury	4 □Donation 5 □Other (Specify) file. nOpe 21. Sign bre of Funeral Service Licensee		Funeral Home
		621 Opossumtown Pike, Fred	
	23a, Part 1, Enter the disease, or complications that caused the death. Do not		rest. Approximate
Physician	shock, or heart failure. List only one cause on each line. Immediate Cause (Final		Interval Between Onset and Death
/Medical	disease or condition resulting in death) a. Due to (or as a consequence of):	industation (100
Examiner	Sequentially list conditions, b	inclustatic c	CA161- 7 MO
D #	if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
and I-trans	that initiated events c. resulting in death) Last Due to (or as a consequence of):		
be executed sician and burial-transit			
ficate ficate phys is the	d		
eath certific attending p	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
death death ad for	in the past 12 months? 1 Ves 2 No	3 Dectopic pregnancy 5 Other (specify)	Month Day Year
that the de ted by the a detached t	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		
res tha igned be del	Part II. Other significant conditions contributing to death but not resulting in the		bacco use contribute to the cause of death?
v requir	nigh /31000 /1	104	es 204No 3 Probably 4 Unknown
e law hesb	nigh stood fi	24a. Was a autop perform	sy prior to completion of cause of
Physician: The la Physician: The la rthis certificate hes ral director, page 2			med? death? 1 Yes 2 No
viciar viciar certif rector		26. Place of Death (Check only or	
Phy Phys	1 105 22 NO 1 Inpatient 2 EN/Outpa	THE SELECTION 4 INDISING HOME SELECTION	ence 6 ☐Other (Specify) ow injury occurred
afte.	1 ∰Natural 5 □ Pending (Month, Day Year) Injur 2 □ Accident investigation	y Work? M 1 □ Yes 2 □ No	
or Attending Phefter death. Director: After the in by the funeral	27. Manner of Death 1	street, factory, office 28f. Location (5 City or Tow	itreet and Number or Rural Route Number, n. State)
itel or rei Di			
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	29a. Certifier (Check only one) Physician: To the best of my knowledge, do 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the time, of	date and place, and due to the cause(s)
To the within Fo the comple	29b. Signature and title of certifier.	29c. License number	29d. Date signed (Month, Day, Year)
70	2 Lynn	014626	NOU 14,2001
\0	30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)	9170/
CV.	(P) G Trus & MB	50, w 1 50 F-	-Ederics MD
State Registra	31. Date filed (Month, Day, Year) NOV 1 5 2006	29c. License number D/4C25 De, Print) 50/ W 1 = 9 56 F-	

State of Maryland / Department of Health and Mental Hygien 2 11 15

Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** David Jeffres Smith 8:05 P.M November 11, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year II Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Yrs. 218-34-6397 1940 Washington, D.C Director 66 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or itema 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12011 Winding Creek Way 20874 U.S.A. death by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Heating, Air Condition College (1-4or 5+) Elementary/Secondary (0-12) Steamfitter Refrigeration Pages 1 and 2 should be filed v itmen of Health and Mental Hygie rtant: if Item 27 is marked other t hjury or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alton Long Smith Rose Marie Arbushitis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Ann Lawhorn/Daughter 12011 Winding Creek Way, Germantown, Maryland 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: if any injury or once. 4 □ Donation 5 □ Other (Specify) Metropolitan Crematorium 11/15/06 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home Damascus, Maryland 20872 Molesworth-Williams P.A., Fu Damascus, Maryland 20872

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examine sician end burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical the use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death the o 9☐ Unknown 9 Unknown ے Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2₽No 1 Yes 2 No 1 Yes of Vital : After this certifical funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1□Yes 2□No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation after death.

I Director: Aft d in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be within 24 hours after de To the Funeral Directo completely filled in by th 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel or Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) Pero, mos D0057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Truong Bao 9715 Medical Center Drive #20, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. P gistrar's Signature NOV 1 5 2006 Correle Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 1 - For Stata Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SALTIMORQ ANE asy 16 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Min Hours 1 M 2 F -28-6385 Director 1ARULAN C Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County in then "neturel", or Iteme 23a or 28e-f show If a Madical Examiner must be notified at 1 Tes 2 No Completed by Funeral Director Baltimore (Kasy) II 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Neyer Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced SIAC Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 12 omasy other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 is marked off jury or other treumatic even ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Julia + Liquid 20a. Method of Disposition DAUGHTER Date 1 Burial 2 Cremation 3 Removal from State Department of Important: If eny injury or once. harles Memoria 11-24-2006 LOWARDTOWN MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Juneral Service Lister 22. Name and Address of Facility Adams FUNCIER Home PA 20605 Agunsco Road Agunsco Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** 00 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to intra-clast cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) the burial-P.O. Box 68760. use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de-23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 2 Fetal death 3 Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the all the detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 Yes 2 No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 1 No Hospital: Other: 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 1 🗌 Inpatient ō 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation death. M 1 Yes 2 No I Director: / 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours after To the Funerel Direct 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSICION 30. Name and address State 2006

DHMH 17 Rev 1/2001

Registrar

Certificate of Death

38159

3. Time of Death

9. Birthplace (State or Foreign Country) New Jersey

White

3 ☐ Probably 4 ☑ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

ASSISTED

LIVING

10d. Inside City Limits

1 ☐ Yes 2 No

To the Hospital 24 hours completely within 2

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 11, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and Iddiess of person who completed cause of death (Item 23a) (Type, Print)

GRACE BLOOKE (HAFMA), M-D. 18100 SCADESCHOOL FOAD SANDY SPRING, MARY CAUS 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State 2006 NUA

State of Maryland / Department of Health and Mental Hygiene 38160 Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 3:25 PM November 17 2006 Anne M. Schreiber /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Denton Caroline Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗙 F Months Days Hours Yrs. 100 Dec 13 1905 Maryland Director 163-03-4121 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show other treumatic event, the Medical Exercitival near total be notified at 1X Yes 2 No Maryland Caroline Denton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21629 U.S.A. 301 Carter Ave. or items 23a death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify Specify: White þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: #filem 21 is marked other than "na any injury or other treumatic avantations." Elementary/Secondary (0-12) College (1-4or 5+) Oil industry 11 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Kirsch Schreiber Michael Schreiber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Greensboro, Maryland 21639 308 N. Main Street Elsie Embert/ niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/22/2006 Greensboro, Maryland Holy CrossCemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Fleegle and Helfenbein Funeral Home, PO Box 160 Greensboro, Maryland 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovas **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physiclan/Medical as the the attending IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Day Month ō 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 230 No 3 Probably 4 □Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 performed? 1 Tes 2 No certificate 1 Yes a No of Vital 26. Place of Death (Check only one) ector, To Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 Tes 2- No 2 ER/Outpatient 3□ DOA ŧ this After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide Hospitel or within 24 hours a filled 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 920 1at 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NUV 4 Registrar

			1 - For State Registrar	State of Ma	aryland / Depa	artment of F			iene g, N2 0 (6 3	8161
	Physici /Medio		Decedent's Name (First, Middle, Phyllis	Last)	Smith			2. Date of Deat Nov 18, 2		Vear	18:28 M
)	Examir	. 31	4a. Facility Name (If not institution, Memorial Hospita	al		Cumberl		Ta 0 - 15:0	4c. County Allega	ny	
外。	Funeral Director		5. Social Security Number 218-30-0561 Usual Residence of Decedent	. Sex 7. Ag 1□ M 2⊠ F	e (In yrs. last birthday) 79 Yrs.	Il Under 1 Year Months Days	Hours Min.	8. Date of Birth Month Day, Feb 23,	1927	PA PA	e (State or Foreign
	Maryland -f show lied at	tor	10a. State 10b. County Allega	any	10c. City, Town or Lo Cumk	perland				10d.	Inside City Limits 1 X es 2 No
	3a or 28e	Funeral Director	10e. Street and Number 512 Winifred Roa	ad		10f. Zip Code	21502	1	0g. Citizen of V)
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "natural", or Itams 23e or 28e-f show sty injury or other treumatic event, the Medical Examinatinal by multied at 2008.	þ	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Blac	e - American l k, White, etc.	ndian,
Baltimore, Maryland 21215-0036	d within 72 hogiene. sr then "natu tre Medical	To Be Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12		(Give	dent's Usual Occup kind of work done DO NOT use retired ered Nurs	during most of worl d)	king	16b. Kind of Bu	siness/Indust	ry
land	utd be file Aental Hyy rked othe	To Be C	17. Father's Name (First, Middle, La George Dively	ast)			18. Mother's Nam Florence	e (First, Middle, I		90)	
Mary	alth and N	i	19a. Informant's Name/Relationshi Nancy Hodges	о (Турв, Print) daug	hter 3 Re	ng Address (Street egatta Cou	and Number or Rui	Ridgel	r, City or Town, ey	State, Zip Co	V 26753
imore	Pages 1 anneal of He		20a. Method of Disposition 1 Ø Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		20b. Place of Disponsion Sunset Men	matory or other place		Date 11/21/2006	20c. Location - Cumbe	•	, State MD
Balt	permit. Departrimporte eny inju		21. Signatu Funeral Service Li	censee ////	W 2		is Fundiyal Ho ginia Avenue		and, MD 2	21502	
8760,	Physician /Medical Examiner stee penal-Itansit	al Examiner	23a. Fart. Enter the disease, or commodiate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	d the death. Do not en ne. IRY ARTERY a consequence of): a consequence of):		ng, such as cardiac	or respiratory arr	est,	Int	pproximate lerval Between nset and Death
P.O. Box 68	death certified attending	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	у			te of delivery nth Da	y Year
	S	þ	Part II. Other significant condition	s contributing to death b	out not resulting in the u	inderlying cause giv	ven in Part I.	23e. Did to	bacco use cont		eause of death? y 4 ∐Unknown
of Vital Records,	The ate h page	Completed						24a. Was a autops perford	med2	Were autopsy prior to complete death?	lindings available etion of cause of
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag	lon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner ol Death 1 Natural 5 Pending			of 28c. Injur	ner: 4 ☐ Nursing H	th (Check only or ome 5 Reside 28d. Describe he	ence 6 🗆 Oth		
Division	l or Attending after death. Director: Aftei I in by the fune	Certification:	2 Accident investigation of Could not determine the Accidence of Could not determine the Accidence of the Accidence of the Accidence of the Accidence of the Accident of the A	ot be 28e. Place of In	jury - At home, farm, st tc. (Specify)			28f. Location (Si City or Town		er or Rural R	oute Number,
_	To the Hospitel within 24 hours a To the Funerel completely filled	edical C		Physician: To the best xaminer: On the basis of and manner st	of examination and/or in						
)	To the within 2 To the complex	Me	29b. Signature and title of certifier	-o Brins	<u>~</u>		se number 014865		Pod. Date signe		t 2006
Section 2	St Regist	ate rar	30. Name and address of person we Robustiano Ba 31. Date liled (Month, Day, Year)	rrera M.D.		. Hosp Me	ed Bldg Cu	umberlan	d MD 2	1502	

State of Maryland / Department of Health and Mental Hygiene 1- State Amend PI,27,28a-f, perME, g864, 2/7/Orer tificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 14, 2006 Physician CLETA DELORES TOOMEY 1500 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June 15, 1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 ₩ F Hours Min Ohio 77 300-24-9424 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Yes 2□No Director Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 8713 Oakmont Street 20877 U.S.A. Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3X Widowed 4 □ Divorced Specify: White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Child Care Provider Child Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental I int: If item 27 Is marked of Gary Cameron Anna Wittek ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Toomey / Son 138 Village Road, Steuben, Maine 04680 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. X Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem. Gardens 11/18/06 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Juneral Fervice icensee ROBERT and Address of Facility & SON, FUNERAL HOMES, P.A. 615 EAST MAIN ST., THURMONT, MD 21788 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hematoma Subdural **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ atrial librillation on Counsdir 1 Yes 2 No 3 Probably 4 Unknown Completed diabetes mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page After this certificate dementa perform Alzheimeris 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death Check only one) Hospital: 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 1√Yes 2 No Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Valural 5 Pending death. investigation 2 X Accident 1 ☐ Yes 2 📉 No reral Director: / unknown unknown probable fall 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide unknown unknown within 24 hours a the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D59738 November 15, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Brive Rockville, MD 20010 Alicia T. Mistry 9901 31. Date filed (Month, Day, Year) strar's Signature NOV 1 7 2006 Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Shelley M. Thomp		n S I- For State	tate of Maryla		epartment o Certificate o		and	Mental Hy	giene	eg. No. 20	06 3816
Physician		Registrar 1. Decedent's Name (First, Mid-	dle Last)			Death			2. Date of Dea	9	3. Time of Death
Medical Examine	er	Shelle	y M. Tho	ompsor	1				Month Novembe	Day Year r 16, 2006	0809 hrs
		4a. Facility Name (if not instituti 25 Whitehall Circle	on, give street and no	umber)		4b. City, Tow Elkton	n, or Lo	ocation of Death		4c County of [Cecil	Death
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday)	If Under 1	Year	If Under 24Hrs.	8. Date of Bi		9. Birthplace (State or
Director	1	217 64 9087	1 M 2 X F	52	Yr	Months 3.	Days	Hours Min.	Jan 2	1, 1954	Foreign Country) MD
۸.	-	Usual Residence of Decedent		140-	Cit. Town on Law						
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eath with the Maryland items 23a or 28a-f show any ust be notified at once.	ᇹᅡ	11. Marital Status	12. Was De	cedent Eve		as Decedent	of Hispa	anic Origin? (Spe)- 14. Race - A	American Indian, Black,
r death wi	Fune		Married Armed F	2 X X			1	Mexican, Puerto F	(ican, etc.)	White, e	
rs afte ural", miner	≥ -	3 Widowed 4 X D 15. Decedent's Education (Sp	ivorced If Yes, Give Ye or Dates:		ed) 16a Decede	Yes 2	,	s <i>pecify:</i> n (Give kind of wo	ork done	Specify: 16b. Kind of Busin	White
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4D 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shront event, the Medical Examiner must be notified at once the Tarley or the Alexandre for	17. Father's Name (First, Middle				-1	18			Maiden Surname)		
21215 ould be fill Mental F marked ic event, t	8	John Wil: 19a. Informant's Name/Relation	ton Smith		19b. Mailir	g Address (Street a	Elizabe	th L.	Kidwell mber, City or Town,	State, Zip Code)
MD d 2 shot lith and	-	Jennifer Thom		hter)						n. MD 219	
	Ī	20a. Method of Disposition 1 X Burial 2 Crematic			20b. Place of Dispo crematory or o	sition (Name of	Vov	eter 24 200	Pate	20c. Location - Ci	ty or Town, State
Pages nent ol ant: Por oth		4 Donation 5 Other 9		OIII Otate	Resurrect	ion Ce	met	ery		Clinton	, Maryland
Baltimore, permit. Pages 1 an Department of Hea Important: If itel		21. Signature of Funeral Servic	E Licensee		22.	Name and Ad	dress o	^{f Facility} Lee	Funera	1 Home, I	nc 6633 01d
Physician	4	23a Part I. Enter the disease, of	moo.25 or complications that of		A	lexand	ria	Ferry R	oad. C	linton. M	D 20735
Medicut		failure. List only one caus	e on each line.								Between Onset and Death
xaminer		Immediate Cause (Final diseas or condition resulting in death)	Due to (or as	a conseque	<u>intoxication</u>	on (Fine	xeri	ne and De	VER BEED	arphen)	=======================================
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		cause. Enter Underlying Cause (Disease or injury that initiated	9 с								
ted ansit		events resulting in death) Last	Due to (or as	a conseque	nce of):						
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/ital	o Be	examiner?	Hospital: 1	Inpatient	2 ER/Outpatien		10	thor:		Residence 6	Other: Scene
1 of V	┝┝	27. Manner of Death	28a. Date (Mont	e of Injury h, Day,Year)	28b. Time of				28d. Describe	how injury occurred	
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		Theodor.	11. Fin	4.11	amos.		D.C.M	.E.		November 17	, 2006
		30. Name and address of person Theodore M. King, Ji			(Item 23a) cal Examiner	111 Penr	n Stre	et, Baltimore	MD 2120	1	
Sta	te	31. Date filed (Month, Day, Year	r) 32. R	sistrar's S	ignature?	ask I				-	
Registr		NOV 3	0 2006	A Section	1 10 pg	To The San San San San San San San San San San					

		1 = For State Registrar	State of Maryl		artment o		nd Mental Hy	giene (06 38164
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Funeral	2	5. Social Security Number 6. S	ex 7. Age (In	vrs. last birthday,	If Under 1 Ye		4 Hrs. 8. Date of Bir Min. (Month, Da	1	9. Birthplace (State or Foreign
Director		162-24-7186 Usual Residence of Decedent	□M 2X0F 76	5 Yrs.	MONINS	lys Hours	Min. 8. Date of Bir (Month, Date of July 2	0 1930	Pennsylvania
/land		10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
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or 28	Dire	10e. Street and Number			10f. Zip Cod			10g. Citizen of	
eath v na 23e	Funeral Director	210 Winchester Co	12. Was Decedent Ever i	0116 12		21401	n2 (Consider Van er No		JSA e - American Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "naturel", or Itema 23e or 28e-1 ehow appringury or other traumatic event, the Medical Examinar must be notified at ance.	by	† Never Married XXMarried 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify C		n? (Specify Yes or No Puerto Rican, etc.)	Specify	ck, White, etc.
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uld be Mental rked o	To Be	Bill Gallentine					ldred Hurs		
2 short and his ma		19a. Informant's Name/Relationship (7	Гуре, Print)	19b. Maili	ng Address (Str	eet and Number	or Rural Route Number	er, City or Town,	State, Zip Code)
1 and 1 and 1 dealth om 27 therefore the 1 there in 1 there is the		Thomas J. Wohlger 20a. Method of Disposition		1) 1011 b. Place of Dispo			et, Annapo		
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ortme ortani injury	ļ.	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Light		letro Cr		L Idress of Facility	L - 9-2006	Baltimo	re, MD
Dep mb out		175- 1. CX	n-		Hardes	ty Funer	cal Home, l enue, Anna		D 21/401
Physician pe executed hysician and physician and physician and the prinai-transit	Examiner	23a. Part1. Enter the disease, or composition in the composition of the composition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	sequence of): Sequence of): sequence of):			TIA CCIDOW		Approximate interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Or the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	etal death 3[□Ectopic pregna □ Other (specify,			23d. Dat Moi	e of delivery nth Day Year
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To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manne: Death 1 atural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		28b. Time of Injury	V	njuryat Work? □Yes 2□No	ì	now injury occurr	be
tal or At s after d al Direct ed in by	Certifi	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office	ce	28f. Location (S City or Tow	Street and Numbern, State)	er or Rural Route Number,
e Hospit 124 hour Euner letely fill	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, death ination and/or in	occurred at the vestigation, in m	e time, date and pay opinion, death	place, and due to the occurred at the time,	cause(s) and ma date and place, a	nner as stated. Ind due to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	A Sphin	MD		ense number 24636	0	Noveme	(Month, Day, Year) 300 8 7006
9201		30. Name a ddress of person who c	completed cause of death (I	tem 23a) (Type,	Print) //		1		21108
2		MACHAEL AN	XXXVII 8601	VETERA	NSHIGH	WAYN	ILLARSVILL	omp	4108
Sta	ite	31. Date filed (Month, Day, Year)	Registrar's Sig	gnature	Ari .	72.		177	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O C

			For State Registrar	State of Marylar		tificate of			g. No.	38165
			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Clarence Freder	ick Wilson				November		11:55 AM
) `	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of Deatl	n	4c. County of Dea	ath
			19 Shore Drive			North			Cecil	
	Funeral Director		5. Social Security Number 222-07-2160 6. Septimize 122 160 122 160 122 160 162 162 162 162 162 162 162 162 162 162	7. Age (In yrs. 84	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 4,	Year) 9. Bi	rthplace (State or Foreign Country) elaware
	land land		10a. State 10b. County	10c. Ci	y, Town or Lo	cation				10d. Inside City Limits
	Mary Hath	ţō	Maryland Cecil	Non	th Eas	t				1 ☐ Yes 2 XNo
	or 286	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?
	23a d		19 Shore Drive			21901		11:	nited Sta	tes
	tems	Funeral		12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	erican Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other treumatic evant, the Modical Examinar natal be multiled at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No Arn If Yes, Give Arn Year or Dates: 1938~	ny	☐ Yes 2X No	Specify:		Specify: W	hite
ဝို	2 hou	ted	15. Decedent's Edu	cation	16a. Deced	lent's Usual Occup	ation	1	6b. Kind of Business	
215	Bn n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done of NOT use retired	during most of wor d)	rking		
7	filed wi Hygien ther th	Son	12			Mechanic			Marine	
P L	be fill d off	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, M	aiden Sumame)	
2	12 should be to and Mental I is marked of iseumatic eva	P	Clan Cooper Wils 19a. Informant's Name/Relationship (Ty		10h Mailie	a Addross (Stroot	Louisa		City or Town, State,	Zin Codol
Maryland 21215-0036	and 2 s eeith an n 27 is i		Mabel G. Wilson /	•					ryland 2	
Baltimore,	permit. Pages 1 an Department of Heel Important: If Item 2 any injury or other <u>once</u> .	1	20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of natory or other place		Date 2	Oc. Location - City o	
Ë	Pages nent of int: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Cemeter	1 110 4	ember 2006 N	ew Castle	. Delaware
aĦ	permit. DepartmImports Imports any inju		21. Signature of Funeral Service Lice			. Name and Addre			neral Home	
<u> </u>	89 = 9		pho of							aryland21901
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat re cause on each line.	h. Do not ente	er the mode of dyin	ng, such as cardiad	or respiratory arres	st,	Approximate Interval Between Onset and Death
ž	Physician		Immediate Cause (Final disease or condition resulting in death)	Metasta	tic o	carcin	oid t	umer		5 years
	/Medical Examiner		1	Due to (or as a consec	uence of):		•			
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	uerice of).					
	od d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	lificate be executed g physicien and as the burial-transit	Exa	resulting in death) Last	Due to (or as a conseq	juence of):					
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			IF FEMALE:	3c. If yes, outcome of pregna	ancv				23d. Date of de	a live a c
Вох	w requires that the death cer been signed by the attendir should be detached for use	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	ıldeath 3⊑	Ectopic pregnancy Other (specify)	1		Month Month	Day Year
P.O.	t the c by the achec	hysi	9 Unknown	9□ Unknown						
	ss that gned l	by P	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
bro	equire sen sis ould b	ted						1 🗆 Yes	s 2.0€No 3□F	Probably 4 Unknown
ec	law f	Completed						24a. Was an autopsy	prior to	autopsy findings available completion of cause of
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Ë	siciar certif recto	Be	25. Was case referred to medical examiner?	lospital:	IED/O	Oth	or	ath (Check only one		
ō	y Phy er this eral d	7: To	1 ☐ Yes 2 No	28a. Date of Injury	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injur	4 [_] (40[Silly	28d. Describe how	nce 6 Other (Sp. v injury occurred	ecity)
Division of Vital Records,	nding eth. r: Afte	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 ∏No			
<u>≥</u>	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
	ital o irs aft ral Di lled in			Į.						
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after deeth. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the ting estigation, in my o	me, date and place pinion, death occu	e, and due to the cau irred at the time, dat	use(s) and manner a te and place, and du	as stated. le to the cause(s)
	o the	Med	29b. Signature and tiple of certifier	and manner stated.		29c. Licens	e number	29	d. Date signed (Mor	nth, Day, Year)
	,		> It terk	es. MD		D	15314	+ /	1/ seem	per 17 2006
	(at)		30. Name and address of person who co	impleted cause of death (Iter	n 23a) (Type,	Print)	, ,	1/ 4		
	W'		H Farkas, MP	Scalin S 32. Registrar's Signa	Hospie	ce 137	3 N. Br	idge ST	Elkton	ber 17,2006
	Sta Registi		31. Date filed (Month, Dáy, Year) NOV 1 7 201	Al-	Ru /			,		
DH	MH 17 Rev 1/2	-,0	NOV 1 7 200	Deliver 1	or Ago	en la company de				
					ORIGI	NAL				

State of Maryland / Department of Health and Mental Hygien $olimits \cup \cup \cup$ Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November 9 **Physician** 2006 11:35 AM Rankin Bruce /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year II Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug., 22,1945 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 ☐ F 408-80-0118 61 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Gaithersburg Directo Montgomery 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 23a or 20879 1532 Tanyard Hill Road United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify: by 3 ☐ Widowed 4 N Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry National Oceanic & Elementary/Secondary (0-12) College (1-4or 5+) Atmospheric Administration Geodesist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ortent: if Item 27 ie marked or injury or other traumatic eve permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 ie marked o Gilbert Ward Beatrice Foren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer M. Ward / Daughter 10202 Nolan Drive, Rockville, MD 20850 20b. Place of Disposition (Name of cometery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State November 14, 2006 1 ☐ Burial 2 DCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home, 10 East 21. Signature of Funeral Service Licensee TRAY A. STUVER Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician OROPHARYNGEAL CARCINOMA 121105 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Jovember 9, 2006 11: ģ CARCINOMA 2 🗆 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Medical Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie Milk Prigams D23308 11.10.2006 30. Name and address of person wo completed cause of death (Item 23a) (Type, Print) VICTOR M. PRIEGO, MD 8430 ROCKLEDGE DA. #4100 BETHESOS, MD 2081>

Registrar

31. Date filed (Month, Day, Year) 15



P.O. Box 68760.

Rankin Bruce

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			For Stata Registrar	State of Maryla		•	ent of He ate of D		мепта		2006	38167
						ver unica	ale of D	eaui	2 Dat	Reg. N	12000	3. Time of Death
	Physici /Medic	_	Decedent's Name (First, Middle, Last William	Harold Weir					Nov:	ember	21, 2000	0256 M
	Examir		4a. Facility Name (If not institution, give				•	ocation of Deat	th	4	lc. County of Dea	ath
	100		EASTON MEMOR 5. Social Security Number 6. Se				EAST der 1 Year	If Under 24 Hrs	. A Date	e of Birth	TAL	ROT rthplace (State or Foreign
15	Funeral Director		213-46-1622 Usual Residence of Decedent	2M 2□F	89 Yr	Month		Hours Min.	. (Mo	e of Birth nth, Day, Yea UUY 29, 1	917 No.	rth Dakota
	land land		10a. State 10b. County	10c. 0	City, Town	or Location						10d. Inside City Limits
	Mary First	ţō	Maryland Caroline		Feder	alsbu	2 C					M☐Yes 2☐No
~	death with the ms 23s or 28s	Director	10e. Street and Number				Zip Code			10g. (Citizen of What C	ountry?
للِّ	23a c	<u>a</u>	618 Liberty Road			4	21632			Uni	ted Star	tes of Americ
8	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S.	13. Was Dec If Yes, s	cedent of His pecify Cuban	panic Origin? (9 , Mexican, Puer	Specify Ye to Rican,	s or No-	14. Race - Am Black, Whi	erican Indian,
$\mathcal{U}_{\mathcal{L}if}$ \mathcal{U}_{III}_{IGM} \mathcal{H} Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23s or 28s-f show any higher to other treumatic svent, its Medical Examinar must be notified at any higher.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 전 No ff Yes, Give Year or Dates:		1 🗆 Yes	2 [™] No	Specify:			Specify: (Caucasian
- '	72 h	etec	15. Decedent's Edu (Specify only highest grad	ucation de completed)	(0	Give kind of	sual Occupat work done du	ion vring most of wo	nking	16b.	Kind of Business	s/Industry
₹ 121	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	ife. DO NOT	olicem	an			aw Enfo	rooman t
1/C	Hygie thar ant, in		11 HS Grad 17. Father's Name (First, Middle, Last)		31	we re		I8. Mother's Na	me (First,			icemeni
an	ld be ental kad o	To Be	William A	Harold Weir				Mary	Este	lle Du	llu	
a Z	2 shoul and Me is mark eumati	-	19a. Informant's Name/Refationship (T)	ype, Print)	19b. A	Mailing Addre	ess (Street ar				or Town, State,	Zip Code)
₹.	and 2 alth a 127 is		Linda W. Tritapoe	2 Daughter	8	Magnos	lia St	reet, E	aston	, Mary	land 216	601
Dre	of He of He if Item		20a. Method of Disposition 1 Surial 2 Cremation 3 I		. Place of D cemetery,	isposition (A crematory o	Name of or other place,)	Date	20c.	Location - City o	r Town, State
- J.E	Pag ment ant: I ury o		4 Donation 5 Other (Specify,	Spa	ring	Hill (emete	y		Eα	ston, Mo	ryland
Z HE	permit. Page Department i Important: If any Injury or once.		21. Signature of Funeral Service Ligens	nous .		22. Name M0074	and Address	of Facility	e. P.	A .		
	20 = 0		23a. Part1. Enter the disease, or comp	liantings that sound the de	ath Done	12 Se	outh S.	econd S	treet	Dent	on, Mary	land 21629 Approximate
100			shock, or heart failure. List only o	ine cause on each line.		è		() :		atory arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. CONGEST		hea	Lt -	failu,	re			Hours
	Examiner			Anem								Days
	N	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons):				·		
	nd ransi	Examiner	that initiated events	c								
760,	te be executed ystcien and e burial-transit	Ě	resulting in death) Last	Due to (or as a cons	equence of)	h:						
6876	physic the b	dical	•	d								
9 × 6	law requires that the death certificate i as been signed by the attending physi 2 should be detached for use as the t	Physician/Medi	IF FEMALE:	23c. If yes, outcome of prec	nancy						23d. Date of de	divery
Вох	atter after of for u	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Fe 4 Pregnant at time of	etal death	3 Ectopic	pregnancy (specify)				Month	Day Year
P.O.	t the c by the	hys	9 Unknown	9□ Unknown								
ν, π	res that the designed by the a	by P	Part If. Other significant conditions co	ntributing to death but not r	esulting in t	he underlyin	g cause giver	n in Part I.	23	e. Did tobacco	o use contribute t	o the cause of death?
ord	v require been si should b	ted	- Fitrial p	brillation						1 🗆 Yes	2 □ No 3 □ P	robabfy 4 ⊠Unknown
ပိ	law r las be	Completed							24	a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u>=</u>	The cate has page	ပ္ပ							1	performed? Yes 2⊠N		
/ita	sician: The law certificate has t irector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			Othor	26. Place of De				
ot	Physician: r this certifica ral director,	To.	1 Yes 2 Nanner of Death	1 Enpatient 2			DOA Other	4 Nursing	-	Residence	6 Other (Spe	ecify)
no	a te	tlon	1 SNaturaf 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Inji		Work?	es 2 🗆 No	200. De	SCHOO HOW III	jury occurred	
Division of Vital Records,	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At	home, fam	n, street, fact			28f. Loc	ation (Street	and Number or F	Rural Route Number,
ρ	urs after orel Dire	Certification:	4 Homelde	building, etc. (Spe						y or Town, Sta		
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier 1 to Certifying Phy (Check only one) 2 ■ Medical Exam	rsician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, of ination and/	death occurre or investigati	ed at the time ion, in my opi	e, date and place nion, death occ	e, and due urred at th	to the cause e time, date a	(s) and manner a ind place, and du	s stated. e to the cause(s)
	To the withing To the comp	Σ	29b. Signature and title of certifier	1 -1	,	100	29c. License		1. 0-		ate signed (Mon	
			Laishmu	mayanatho	an 1	AID	DO	5 / /	47	Mo	vembe	r212006
			30. Name and address of person who o						,	6	M	
9.		ate	Lakshmi Vaidyanaz 31. Date filed (Month, Day, Year)	32 Segistrar's Sig		uth Wa	isningi	con Stre	cet,	caston	, Maryla	nd 21601
	Sta Regist		NOV 2 / 200		N.	the and	1					

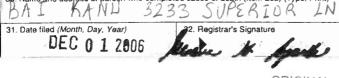
			1 - For State Registrar	state of Man	·		lealth and N		_	38168
П	Physici	an	1. Decedent's Name (First, Middle, Last) Tew W. Y	011				2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give stre			4b. City, Town, or	r Location of Death	Novem her	15 200 4c. County of Deat	
1	Exami		Ellicott City Nursi	ng&Rehabi	litation	E	llicott C	ity	Howa	
	Funeral Director		5. Social Security Number 212–18–9463 Usual Residence of Decedent	7. Age (III	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1)		hplace (State or Foreign huntry) hina
	yland M		10a. State 10b. County	10	C. City, Town or Lo					10d. Inside City Limits
	Ba-fst	Director	Md. Howard		E11	icott Cit	У			1 ☐ Yes 2 🔀 No
	with the	Dire	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Co	untry?
	ms 23	Funerai	3000 N.Ridge Rd. 11. Marital Status 12.	Was Decedent Eve	r in U.S. 13.	210 Was Decedent of H If Yes, specify Cuba		ecify Yes or No-	USA 14. Race - Ame	rican Indian,
920	d within 72 hours after death with the Maryland Jiene. I then "natural", or Itams 23e or 28e-f show The Madical Examinar must be indiffed at	by	1 ☐ Never Married 2 ☐ Married 3 反 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 ☐ Yes 🌠 No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, White	e, etc. Asian
21215-0036	nin 72 ho in "natu Wedical	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	ompleted)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work f)	ing 16	6b. Kind of Business/	
212	filed within I Hygiene. other then "		3yrs 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Re	staurateu		e (First, Middle, Ma	taurant	
Maryland	e d la la la la la la la la la la la la la	To Be	Jew Hin					om Lee	uden Sumame)	
Man	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (<i>Type</i> , Beverly Weston/Daugh						City or Town, State, Z e,Md. 212	
Baltimore,	m O - L		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem	Oval II Olli State	20b. Place of Dispo cemetery, crer	sition (Name of matory or other place	θ)	Date 20	c. Location - City or	Town, State
altin	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lisens	1.4	22	. Name and Addres	ss of Facility Hal	rry H.Wit	altimore,1 zke's Fam:	ily F.H.Inc.
	40 E 2 9		mare P. y							,Md. 21043
	rnysician /Medical		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of immediate Cause (Final disease or condition resulting in death)	ause on each line.	cleratic	_	-	240		Approximate Interval Between Onset and Death
	Examiner	e	Sequentially list conditions, b. – if any, leading to immediate	Due to (or as a co	onsoquence oty.					
	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
8760,	icate be executed physician and s the burial-transit	cal E	d	Due to (or as a co	onsequence of):					
P.O. Box 68	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contrib	uting to death but no	ot resulting in the ur	nderlying cause give	on in Part I.	23e. Did toba	cco use contribute to	the cause of death?
	The ate ha	Completed						24a. Was an autopsy performe	dy prior to c	topsy findings available ompletion of cause of
/ita	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ia a l		100		(Check only one)		
ō	Phys this ral dir	- To	1 ☐ Yes 2 No Hosp	1 ☐ Inpatient Ba. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of	t 3 DOA Othe 28c. Injury Work	Nursing Ho	me 5 Residence 28d. Describe how	e 6 □Other (Specinius)	ify)
ion	Attanding F r death. actor: After by the funer	ation	1 □Natural 5 □ Pending 2 □ Accident investigation	ESG. DOSGIDO NON	injury cocurred					
=	al or Attances after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - building, etc. (S	At home, farm, stre Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
	To the Hospital or At within 24 hours after of To tha Funeral Dirac completely filled in by	edical C	29a. Certifier (Check only one) Certifying Physici 2 Medical Examiner	an: To the best of m On the basis of exa and manner stated.	y knowledge, death amination and/or inv	occurred at the time restigation, in my op	e, date and place, pinion, death occurr	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
ı.	To the within To the comple	Σ	29b. Signature and title of certifier			29c. License		29d	Date signed (Month	Day, Year)
20	2		30. Name and address of person who comp Ramesh Sabapall 31. Date filed (Month, Day, Year)	eted cause of death	(Item 23a) (Type,	Print)	10.4 0	1 0 1	+ M	10 0000
	Sta	te	Kame(h da bapa/M 31. Date filed (Month, Day, Year)	32. Posistrar's	Signature	rural N	CCK FOL	a pall	imire "19	ylan yezl
	Registr		NOV 1 4 2006	Alexan	, B. A	neth				

State of Maryland / Department of Health and Mental Hygien 000

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			Registrar	•	Certificate of Death	Rag. f	1 0.		
١	Physici /Medic		1. Decedent's Name (First, Middle, Last) 9 RANCES LOLI	ARRAS		2. Date of Death Month	Day Year	3. Time of Death $0520A \text{ M}$	
	Examin		4a. Facility Name (If not institution, give st CARROLL HOSPITA	reet and number) L CENTER	4b. City, Town, or Location of Death WES TMINSTER	}	4c. County of Death CARRO	LL	
	Funeral Director		5. Social Security Number 220-07-9634 Usual Residence of Decedent	M 2⊠F 7. Age (In yrs. last birth	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Yea		nplace (State or Foreign untry) 「VIRGINIA	
	e Maryland ta-f ahow	ctor	10a. State 10b. County MD CARROI	JL 10c. City, Town WES	or Location TMINSTER			10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	th with th	al Director	10e. Street and Number 2524 KAREN WAY		10f. Zip Code 21157	-	Citizen of What Col JSA	untry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23e or 28e-f ahow any injury or other traumatic event, Ite Medical Exartment must be notified at ance.	by Funeral	11. Marital Status 1: 1 Never Married 2 Married 3 Wildowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: W		
Maryland 21215-0036	d within 72 ho piene. r than "natur tre Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	completed)	Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired) HOUSEWIFE	rking	b. Kind of Business/Industry OME MAKING		
ng	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)	ICHARD MICHAEI		me <i>(First, Middle, M</i> aid LIE REI			
	should nd Mer marke marke	ဥ	19a. Informant's Name/Relationship (Typ		Mailing Address (Street and Number or Ru			Tip Code)	
, Ma	and 2 ealth a m 27 is		LILLIE A. RHOAD		The state of the s	WESTMINST			
nore	Pages 1 nent of H int: if ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Disposition (Name of y, crematory or other place) ARROLL CREMATORY		Location - City or I		
Baltimore,	permit. P Departme Importan any injur		3. Signal 1914 Furferal Service License		22. Name and Address of Facility FL 254 E. MAIN ST.	ETCHER FU	JNERAL H		
4	Physician /Medical		23a. Part 1. Enter the disease, or complic shock, or beart failure. List only one Immediate Cause (Final disease or condition resulting in death)	PNEUMONIA	ot enter the mode of dying, such as cardiac			Approximate Interval Between Onset and Death	
I	Examiner		Sequentially list conditions b.	Due to (or as a consequence of CONGESTIVE	HEART FAILUP	F			
	Marit Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Non ST ELE	VATION MYOLARDI	AL INFA	RCTION		
68760,	ate be executy hysicien and the burial-tra	ilcai Exa	that initiated events c. resulting in death) Last	Due to (or as a consequence of LM ROWIC OBS	OF STRUCTIVE PULMO	NARY DI	SEASE		
Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ac. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	ivery Day Year	
s, P.O.	es that t gned by be deta	by Ph	Part II. Other significant conditions conf	•	the underlying cause given in Part I.			the cause of death?	
ord	requir been si should I	eted	OSTEO POROSI COMPRESSION		THE VERTEBRAL	1 ☐ Yes 24a. Was an		obably 4 Munknown	
Rec	The law ite has page 2 :	Completed	SPINE.	71010 (0.10	12/12/11	autopsy performed	? death?	topsy findings available completion of cause of	
Vital	ician: sertifica ector, p	BeC	25. Was case referred to medical examiner?	ospital: , , , ,	Others	ath Check only one			
jo	g Phys er this eral dir	п: То	27. Manner of Death	28a. Date of Injury 28b. T	thattent 30 DOX 40 Italiang 1	lome 5 ☐ Residence 28d. Describe how in		cify)	
Division of Vital Records,	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, St	and Number or Ru ate)	Iral Route Number,	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical Ce			, death occurred at the time, date and place d/or investigation, in my opinion, death occu				
ľ	To th within To th compl	Me	29b. Signature and title of certifier	M-D.	29c. License number 0 0 0 5 8 5 8 0) 11	Date signed (Monti	h, Day, Year)	
	5	1	30. Name and address of person who con	mpleted cause of death (Item 23a) (Type, Print) R LN, B 21. BO	WIE, MD	20715		

State Registrar DHMH 17 Rev 1/2001



State Registrar 31. Date filed (Month, Day, Year)

DEC 0 1 2006

Registrar's Signature

				State of M	aryland / Der			•	•	. 00171
			For State Registrar		C	ertificate of	Death	Re	eg. No.	0 30111
	Physici	an	1. Decedent's Name (First, Middle,	Last)	Λ	15.00		2. Date of Deat Month		3. Time of Death
	/Medic	al	4a. Facility Name (If not institution,	nive street and number)	17	Lisea Town o	r Location of Death	Nassa	4c. County of	
	Examin	ier	Johns Hopkins 1		are Cente		2701		,	rose City
	Funeral Director				e (In yrs. last birthda 43 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, OCT/3)	1963	9. Birthplace (State or Foreign Country) Maryland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Ba-f sho	ctor	MD Balti	more	Essex					1 ☐ Yes ŽÃ No
	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show the Maulcal Examiner court be natified at	by Funeral Director	10e. Street and Number 1739 Earhart	Road		10f. Zip Code 21221	1	1	0g. Citizen of W USA	hat Country?
	ems 2	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	3. Was Decedent of H	dispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc.
936	urs afte	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Privorced	d 1 □Yes 2 □X If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🕱 No	Specify:		Specify:	White
2-0	72 ho	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dec	cedent's Usual Occup ve kind of work done . DO NOT use retired	nation during most of worki	ing	16b. Kind of Bus	iness/Industry
121	within iene. than	ompi	Elementary/Secondary (0-12)	College (1-4or		sing Ass			Мес	dical
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show ampringery or other traumatic event, the Marical Examination and the nutified at ance.	To Be C	17. Father's Name (First, Middle, La Frank S. Alis				18. Mother's Name	e (First, Middle, M Phillip		y
Mary	12 sho		19a. Informant's Name/Relationshi Frank M. Ali			iling Address (Street) 3 Roseda				
<u>ē</u>	t Healt Healt item 2 other		20a. Method of Disposition		20h. Place of Dis	position (Name of				City or Town, State
Baltimore,	Page ment o ant: if ury or		X☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe	ocity)		rematory or other places of Fait		0/06	Rossy	ville MD
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Li	consee	Elish.	22. Name and Addre	30			Balto. MD sex 21221
			23a. Part . Enter the disease, or c shock, or heart failure. List or	cations that cause no cause on each li	the feath. Do not e					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Metas	tatic c		Carre			Onset and Death
	/Medical Examiner			Due to (or as	a consequence of):	1 Chate	intim			Trins
18.	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of).	10000				- Courts
M.	te be executed ysician and te burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
	ate be nysicia he bur	cai		d						
x 68	leath certificate t attending physic	/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy				204 D-10	of delivery
P.O. Box	the thec	by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1⊜Live birth 4⊜Pregnant a 9⊡Unknown	2 Fetal death	B Ectopic pregnancy Control (Specify)	у		Mon!	of delivery th Day Year
G,	gned by	by Pr	Part II. Other significant condition	s contributing to death t	out not resulting in the	underlying cause giv	ven in Part I.		1	bute to the cause of death?
ord	w requires that s been signed b should be det							1 🗆 Ye	90074 =	3 ☐ Probably 4 ☐Unknown
Division of Vital Records,	The law cate has b	Completed						24a. Was a autops perform 1 \(\text{Yes} \) 2	v pr	ere autopsy findings available for to completion of cause of sath? Yes 2 No
Vita	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	ent 2 ER/Outpat	ort ac pos Oth	26. Place of Death	n <i>(Check only on</i> me 5 ☐ Reside		/Carrie
ιof	ding Phys h. After this funeral di	n: To	27. Manner of Death	28a. Date of Inju	ıry 28b. Time	of 28c. Injur	ry at	28d. Describe ho		1-1
sior	Attendin death. ctor: Af y the fur	icatic	Natural 5 Pending investigation in Suicide 6 Could not provide the suicide 5 Pending investigation in the suicide in the suici	ot be an Bloom of to		M 1 🗆	Yes 2 □ No	38f Location /St	root and Mumba	r or Rural Route Number,
Div	spital or Attendours after death leral Director: filled in by the	Certification:	4 ☐ Homicide determin	building, e	jury - At home, farm, ic. (Specify)	street, ractory, onice		City or Town	, State)	or Harar House Namber,
	Fur 4 b	edicai	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis o and manner st	f examination and/or	ath occurred at the tir investigation, in my o	me, date and place, opinion, death occurr	and due to the cared at the time, da	ause(s) and man ate and place, ar	ner as stated. nd due to the cause(s)
	To the vithin 2 To the complet	Σ	29b. Signature and title of certifier	210		29c. Licens			-	(Month, Day, Year)
	^		30. Name and address of person w	ho completed cause of	eath (Item 23a) (Tvo	e, Print)	500 T	TOPKING	ISAYV	27 2006 IEW CIRCLE
	2		W.3. 6	reeyou	ch Tol	" MD	BALTIM			
	Sta Regist		31. Date filed (Month, Day, Year)	K	ray's Signature	brutes				ı
		4.	DEC 0 1	2006 Library	Ed St M	1				

		1 - State Registrar Certificate of Death Reg. No.															
	L		1. Decedent's Name (First, Middle, Last)							2. Date of D Month)au	V	3. Time of Death		
	hysicia Medic	1	MAble All	io								25 ້	2006	Year	12:00рм		
	xamin		4a. Facility Name (If not institution, give	street and numb	oer)		4b. City,	Town, or	Location	of Death		4	c. County	of Death			
			1320 Windlass	Drive			M.	iddl	e Ri			ŀ	Bal	timo	re		
Fu	neral		5. Social Security Number 6. Se		Age (In yrs.	last birthday)	If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	rth	16000	9. Birthp	lace (State or Foreign try)		
Dire	ector		220-14-7912] M 2[X[F	8	O Yrs.	1410111113	Days	Tiours		June	9, 1	920		ginia		
20	167	}	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	nation								Od. Inside City Limits		
aryla	III III	ž	Md Baltim	020		•								1	1 Tyes 2 No		
₩ ₩ W		ecto			141.	iddle	_										
with t	2	Director	10e. Street and Number 1320 Windlass	D			10f. Zip		20					What Coun	try?		
ath v	ෂ	Funerai				0 101		212		1.0.70			USA				
er de	COL	Š	11. Marital Status	12. Was Decede	es?	.S. 13. V	Yes, spe	cify Cubar	spanic Ori n, Mexicar	n, Puerto I	cify Yes or N Rican, etc.)	0-	14. Race - American Indian, Black, White, etc.				
1215-0036 within 72 hours after death with the Maryland energy and response to the manyland energy and the manyland energy an	9	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date		1	☐ Yes	2[X]No	Specify:			Specify: White					
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e, Mg 1 and 2 Health a	, 5		Fred Allio / son 6153 Cape MAy Road I 20a. Method of Disposition 2 Democrative State 20b. Place of Disposition (Name of competery, crematory or other place) Date										re M	D 21	221		
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			23a. Part1 Enter the disease, or comp	ications that cau	sed the death	h. Do not ente	or the mod	de of dying	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between		
l Physi	ician		23a. Part 1 Enter the disease, of amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Immediate Cause (Final												Onset and Peath		
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ocalificate be executed disconsistent and	use as the burial-transit	/Medicai		d													
	0 00 0 00	Mec	IF FEMALE:														
			23b. Was decedent pregnant in the past 12 months?		h 2∏Feta	I death 3	Ectopic p						23d. Dat Mo	te of delive	ry Day Year		
	hed f	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9□ Unknow	nt at time of do n	eath 5	Other (sp	pecify)				- 1			,		
P.O.	Setac	윤	Part II. Other significant conditions co	ntributing to deal	th but not rose	ulting in the ur	dochioa	21100 0010	on in Dard I		23e Did	tobacco	nuse cont	ributa ta th	e cause of death?		
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E ing	lune i	<u>6</u>	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of (Month,	Day Year)	28b. Time of Injury		28c. Injury Work	?		28d. Describe	now in	lury occurr	· 90	cong		
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To the within 2	omp	∑	29b. Signature and title of certifier				290	c. License	number			29d. D	ate signed	d (Month, L	Day, Year)		
- > -	3) Alto	- Wil).			D-	-38	175	>4	11	-2	7-2	-006		
			30. Name and address of person who co	ompleted cause	of death (Item	n 23a) (Type. I	Print)				1		Λ	10	71221		
	5			S ASBB	M.	700	7 · E	3 AS	TB	RN	1261	10	/V	リリー	41221		
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Registrar

DEC 0 1 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year Physician MICHAEL BARTON 0015 NOVEMBER 2006 14 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTEMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 X M 2 □ F 08/09/1968 NC 38 Director 460-01-4802 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r then "natural", or iteme 23a or 28e-f ehov the Medical Expreimer must be multiled at MD) 1⊠Yes 2 No Director BALTIMORE 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 3737 E. LOMBARD ST. 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc.

AMERICAN within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 21XNo þ 3 Widowed 4 Divorced INDIAN Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH ROOFER ROOFING other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be pe it of Health and Mental EMMA JEAN BARTON unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JIOTO, L. JOTOP, BOBBIE BARTON 3737 E. LOMBARD ST., 2ND FL., BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5712 O DONNELL ST. 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/22/2006 BALTIMORE, MD MT. CARMEL CEM. 21224 21. Signature of Funeral Service Licens 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD Ues 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of) Examiner BACTEREMEA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physician and s the burial-transit END STACE RENAL DISEASE Due to (or as a consequence of) Box 68760 Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death P.0. ed by the a 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown cete has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 □ No 24a. Was an autopsy performed? 1X Yes 2□No Division of Vital 26. Place of Death (Check only one) funeral director Be 25. Was case referred to medical Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 N Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. i or Attend after death Director: / 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitei within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES -000 NOVEMBER 16, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

AVENUE

BALTEMORE, MO

EASTERA

4940

32. Adgistrar's Signature.

Sara L. Benvengi 06-09004 UNK UNK

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No 2. Date of Death 1 Decedent's Name (First Middle Last) Time of Death Physician/ Month Day November 26, 2006 Benvengi 0725 hrs Lynn Medical Examiner Sara 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (if not institution, give street and number) Glen Burnie Anne Arundel Baltimore Washington Medical Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** oreign Days Hours Director 216-06-8579 Country) Maryland 1 M 2 X F May 3,1984 22 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State Yes 2 XNo items 23a or 28a-f show ust be notified at once. Maryland Baltimore Eastwood with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 21224 7022 Conley Street United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes 2 X No 0 White If Yes, Give Year 1 Yes 2 X No specify Widowed Divorced permit Pages I and 2 should be filed within 72 hours afte Department of Iteath and Mental Hyggene Important: If item 27 is marked other than "natural", injury or other transmarie event, the Medical Examiner injury or other transmarie event, and the Medical Examiner. ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Homemaker Own Home 10 Years 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Edward Coburn, Jr. Annette Marie Benvengi 19a. Informant's Name/Relationship (Type, Print) Mother 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ Annette Benvengi Christian 2015 Larkhall Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) Removal from Stat Cremation 3 1 x Burial 11/30/2006 Baltimore, Maryland Other Specify Lawn Cemetery 22. Name and Address of Facility of Funera Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Narcotic (heroin and methadone) intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and the burial - transi sician/Medical X UNPENDED AMENDED #23a,27,28a-f, perME, g862, 12/.11/06 TT Box 68760, IF FFMALE 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Dav Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Phys 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner' Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 🗸 Yes ۵ 28d. Describe how injury occurred 28b. Time of Injury 28c Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: Natural 5 Pending Yes 2 No unknown 11/26/2006 Funeral Director: unknown Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide or Town, State) determined unknown (Specify) 4 unknown Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Wedical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29d Date signed (Month, Day, Year) 29c License number O.C.M.E. November 26, 2006 nd address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, (Month, Day, Year) DEC 0 1 2006 legistrar's Signat State Registra

		For State Registrar	State of Marylan		rtment of F tificate of			leg. No.	J 6	381/5
Physic	, ian	1. Decedent's Name (First, Middle, Last Ann Gille					2. Date of Dea Month	r 26, 2	Year OO6	3. Time of Death 8:45 A M
/Medi Exami		4a. Facility Name (If not institution, give			-	r Location of Deatl		4c. County		0.43 11
	,	Casey House 5. Social Security Number 6. S	ex 7. Age (In yrs.	last hirthday)	Rock	ville I If Under 24 Hrs.	8. Date of Birth	1	ntgor	nery lace (State or Foreign
Funeral Director		239-54-9847	□M 2 X)F 71	Yrs.	Months Days	Hours Min.	Nov • 17	, ^{Year)} 1935	Coun	ch Carolina
Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Howard		y, Town or Lo		ımbia			1	0d. Inside City Limits 1 ☐ Yes 2 No
th with the 23a or 28a ust be not	al Director	10e. Street and Number 7405 Swan Point	Way		10f. Zip Code	1045		10g. Citizen of V Unite		*
ING 21215-0036 be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natura", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes XIX No	lispanic Origin? (S an, Mexican, Puerl Specify:	specify Yes or No- to Rican, etc.)	14. Race Blac Specify	e - Americ k, White, :: Whi	etc.
Maryland 21215-0036 td 2 should be filed within 72 hours af th and Mental Hygiene tris marked other than "natural", or traumatic event, the Medical Exam.	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+) 5+	16a. Deced (Give life. I	dent's Usual Occup kind of work done DO NOT use retired Teacher	oation during most of wor d)	rking	16b. Kind of Bu	ucati	•
d 21 filed w Hygiei ther ti	S	17. Father's Name (First, Middle, Last)			reacher	18. Mother's Nar	me (First, Middle,			
<u> </u>	To Be	Irving	Gillett			Eliza	beth	Chre	ech	
Nore, Maryla ggs 1 and 2 should to the of Health and Ment if item 27 is markee or other traumatic	ľ	19a.Informant's Name/Relationship (Keith Burt / Son		6461	ng Address <i>(Street</i> Linway T	errace,			'	Code)
Baltimore, permit. Pages 1 ar Department of Hea Important: If item 3 any Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.	Hemovai from State		sition (Name of matory or other place ke Cremat		Date 28/06	20c. Location - Belts	-	
Baltimo permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lic	huneum	1.	Rapp ^{an} fune 933 Gist					910
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68760, tificate be ex g physician as the burial	edical		d							
Box eath cert attending for use a	Physician/Mo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1							ery Day Year
cords, P.O. w requires that the d been signed by the s should be detached	b	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to			ne cause of death?
	Completed							med? c	Were auto prior to cor death? I □ Yes	psy findings available inpletion of cause of 2 No
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On or Vital Redung Physician: The Parter this certificate hadrent director, page	ion: To	1 Yes	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Inju	4 □ Nursing F	T	ence 6 XIOthe ow injury occurr		// Hospice
Division or Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director, to	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined					28f. Location (S City or Tow	itreet and Numbern, State)	er or Rura	l Route Number,
To the Hospital within 24 hours a To the Funeral I	Medical C		nysician: To the best of my kno miner: On the basis of examina and manner stated.							
To th within To th	Me	29b. Signature and title of certifier	n'n . 11 .		29c. Licens	oe number 205803		29d. Date signed	d (Month,	Day, Year)
,4		30. Name and address of person who	Milliam completed cause of death (Item	n 23a) (Type,	Print)			1/00.	27,	2006
\ 0		Cynthia M. Will	iams D.O. / 60	01 Mun	caster Mi	ill Rd.,	Rockvill	e, MD	20850)
Si Regis	tate trar	31. Date filed (Month, Day, Year)	32. Tojstrar's Signa	K A	20080					
DHMH 17 Rev 1/	2001	DEA A 1	2000							

06-09043 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Donald Barr 2006 381 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ November 27, 2006 1647 hrs **Medical Examiner** Donald Barr 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mechanicsville St. Mary's 27149 Barton Street 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of 8irth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director Country) MD 212-64-2601 $_{1}[X]_{M}$ 53 Yrs 7-17-1953 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits Yes 2 x No or 28a-f show MD "natural", or items 23a or 28a-f shov Examiner must be notified at once. St. Mary's Mechanicsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27149 Barton Street 20653 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Married Never Married 2 2XX No Yes Specify: white If Yes, Give Year Yes 2 X No specify. Widowed 4 X Divorced ð 16a Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed 2 should be filed within 72 ho n and Montal Hygiene 27 is marked other than "ns Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 12 Pressman Graphics 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laurence Barr Elizabeth P. Barr or other tranmatic event, Be 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24904 Dunnavant Dr. Gaithersburg, MD 20882

Date | 20c. Location - City or Town, State Lisa A. Barr/Ex-wife Pages 1 and 2 sinent of Health ar If item 27 20a Method of Disposition 20b Place of Disposition (Name of cemetery crematory or other place) Burial 2 X Cremation 3 Removal from State 11-30-2006 Beltsville, MD Important: Donation 5 Other Specify: <u>Chesapeake Crematory</u> 22. Name and Address of Facility Cremation + Funeral Alternatives Signature of Funeral Service Licensee ma1358 8717 Green Pastures Dr. Towson, MD 21286 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23c If yes, outcome of pregnancy IF FEMALE 23d Date of delivery 23b Was decedent pregnant in the 3 Ectopic pregnancy Live hirth Fetal death Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <u>چ</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 V Yes 26 Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be Other 4 examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✓ Other; Scene ဥ 1 🗸 Yes 2 No 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Manner of Death Certification: Subject placed plastic bag over head with FOUND: Natural Yes 2 V No 5 Pending propane cylinder To the Funeral Director: Nov 27, 2006 1630 hrs Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 27149 Barton Street, Mechanicsville, MD determined (Specify) Single Family Home Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ture and title of ci 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 28, 2006 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD.

Registral
DHMH 17 Rev 1/2001

OCME 2006

State

31. Date filed (Month, Day, Year)

DEC

distrar's Signature

06-08636

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State of Maryland / Department of Health and Mental Hygiene

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	d State of Maryla	nd / Department of Certificate of	Health and Mental Death		2006	3817	
Physician/ 1. [Decedent's Name (First, Middle,Last)	ıchard		2. Date of Death Month November		Time of Death 0739 hrs	
	Facility Name (if not institution, give street and nur Montgomery General Hospital	nber)	4b. City, Town, or Location of De Olney		4c. County of Death Montgomery		
Funeral 5. S	Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Months Days Hours I	Ars. 8. Date of Birth	(MM/DD/YYYY) 9. Birthp	Washington	
Ust	579-90-8343 1 M 2 X F Land Residence of Decedent	115		000. 23		ry) D.C.	
™ Mo	a. State 10b. County aryland Montgomery	10c. City, Town or Locat	Rockville			Od Inside City Limits Yes 2 X No	
ith the Maryland 23a or 28a-f show notified at once.	e. Street and Number (Unknown)		10f. Zip Code (Unknown)	,	g. Citizen of What Country United Stat		
or items 23a (must be notif	Armod Fo	rces? If Y	s Decedent of Hispanic Origin? es, specify Cuban, Mexican, Pue				
s after death in all, or item by Fune	1 Yes		Yes 2 No specify: ([Specify Wh	ite	
5-0036 ed within 72 hour tygiene with matu to the Medical Exam Completed	Elementary/Secondary (0-12) College (1-	4 or 5+) during m	ost of working life. DO NOT use		N/A	usiry	
	Father's Name (First, Middle, Last) Robert L. Bo	ouchard	18.Mother's Na Iris	me (First, Middle, Ma	aiden Surname) (Unkn	own)	
MD 2121: d 2 should be filth and Mental In the and Mental In To Is mandic event, To Be	a. Informant's Name/Relationship (Type, Print) Robert E. Bouchard / Bro		Address (Street and Number N. Harrison St			ip Code) 205	
more, M Pages I and 3 Perfect of Health mut. If item r other trau	a. Method of Disposition Burial 2 X Cremation 3 Removal from	m State crematory or ot		Date /22/06	20c. Location - City or To		
Baltim permit Pa Departmen Important injury or or	Donation 5 Other Specify: Signature of Funeral Service Licensee	Moo38Z Ra	lame and Address of Facility PP Funeral & Ci	remation S	ervices		
Physician 238	a Part I. Enter the disease, or complications that ca failure. List only one cause on each line	used the death. Do not enter t	3 Gist Ave., State mode of dying, such as cardia	lver Spri	ng MD 20	910 Approximate Interval Between Onset and	
	mediate Cause (Final disease a. Mixed Dr	ug (Methadone and consequence of):	fentanyl) intoxic	ation		Death	
Se if a	equentially list conditions, any, leading to immediate b. Due to (or as a	consequence of):					
E (D	use. Enter Underlying Cause isease or injury that initiated rents resulting in death) Last d.	consequence of):					
burial - transit	77	#23a,27,28a-f, pe	rME, g862, 12/12/0	5 TT			
© # # # ≥ IF	FEMALE: b. Was decedent pregnant in the past 12 months? 23c. If yes, c	outcome of pregnancy orth 2 Fe ant at time of death 5 Of	tal death 3 Ectopic pre		23d Date of delivery Month Day	, Year	
P.O. B shat the d			inderlying cause given in Part I		acco use contribute to the		
Records, P. The law requires the law requires the law been signed age 2 should be dompleted by			-	24a. Was ar autops	24b. Were autop	psy findings available apletion of cause of	
HRec n: The L nificate P or, page	i. Was case referred to medical		26.Place of Death (Che	1 ✓ Yes 2		2 No	
Vital hysician this cert directo	examiner? 1 Yes 2 No Hospital: 1 1	npatient 2 ER/Outpatient	3 ✓ DOA Other Nu	rsing Home 5 R	lesidence 6 Other:		
n of high Ph h h : After t e funeral lon: T	Manner of Death Natural 5 Pending	11	njury 28c. Injury at Work? 1 Yes 2 No		ow injury occurred		
Division of Vital Records, the Hospital or Attending Physician: The law required fine 24 hours after death the Funeral Director: After this certificate has been simpletely filled in by the funeral director, page 2 should the director and Certification: To Be Completee	Accident Investigation Suicide 6 K Could not be determined (Specify)	13/2006 unknown		or Town, Sta	reet and Number or Rural	Ave/ Aspen	
10 pg 10 29 29 29 29	Da Certifier 1 Certifying Physician: To the bes				(s) and manner as started		
2 \$ 2 \$ 3 L	and manner s b. Signature and title of certifier	ated	29c. License number		29d. Date signed (Month		
	(abrill)	+	O.C.M.E.		November 14, 200	6	
0 30	D. Name and address of person who completed cause Zabiullah Ali, M.D. Assistant Medic		n Street, Baltimore, MD	21201			
State ³¹ Registrar	Date filed (Month) Par Ye (1) 1 2006 32. R	pistrar's Signature	ade				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 Month Day Year **Physician** Vovember 28. atherine ,2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner tome Nursing If Under 1 Year | If Under 24 Hrs. 5. Social Security Number (ge (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 💢 F 04/12/1920 Director Pennsylvania 86 204-01-1183 Usual Residence of Decedent r 28a-f show notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Carney Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or or items 23a must 21234 United States Funeral 3512 Orbitan Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status "natural", or item edical Exa<u>miner r</u> 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify: Specify: ģ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 <u> Machinist</u> Factory is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Nellie Sheetz ဂ Henry A. Henninger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau 3512 Orbitan Road Carney, Maryland 21234 <u> Karen Higgs - Niece</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gardens of Faith Cemetery

22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 21231
Approximate Introduction of Respiratory arrest.

Approximate Introduction of Respiratory arrest. 12/04/2006 Baltimore, Maryland 21. Signature of Funeral Service Loc Mus Approximate Interval Between Onset and Death 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail it. List only one cause so ach line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transi and Due to (or as a consequence of): Box 68760, physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 1 Tyes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed 1 Yes 2 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 ☐ Pending investigation Hospital or Attending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D completely filled i 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

inann 31. Date filed (Month, Day, Year)

480

Name and add ass of erson who completed cause of death (Item 23a) (Type, Print)

710

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar				(Certific	ate of	Death)	orreal rij	Reg. No.	2000	5	381	79
ŧ.			Decedent's Name (First, M.	liddle, Las	st)							2. Date of De	ath	Voor	3	. Time of D	eath
	Physici: Medic		Barbara Wo	lfne:	r Bohma	חו						Novem	ber 2	29,200e	5	5:57a	ı M
	Examin	er	4a. Facility Name (If not instit	ution, give	e street and nu	mber)			City, Town, o		of Death			County of Dea			
			Heart Home 5. Social Security Number	6. S	0.7	7. Age (In y	us last hirth		therv		r 24 Hrs.	8. Date of Bir		Baltimo		e (State or	Fomia-
	Funeral Director		329–16–3598 Usual Residence of Deceder	1	M 2 ∑ F	85		Mon		Hours	Min.	April '	ı <i>y, Year)</i>	921	inplaction of the second secon		roreign
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	or 28g	Director	10e. Street and Number					10f	Zip Code				10g. Citiz	en of What C	ountry?	?	
	23a cust b		1414 Front <i>F</i>	ve.					21093				USA				
	items	Funeral	11. Marital Status	N. d. a. and a. al	12. Was Dec	orces?	n U.S.	13. Was D If Yes,	ecedent of I specify Cub	Hispanic O pan, Mexica	rigin? (Spec an, Puerto F	cify Yes or No Rican, etc.))- 1	4. Race - Am Black, Wh		ndian,	
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2-003p	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at		15. Dec (Specify only h	edent's Ed	ducation		16a. I	Decedent's	Jsual Occup	pation	et of working	ng.		d of Busines		ry	
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7	e filed within al Hygiene. other than '		17. Father's Name (First, Min	ddlo Loot	4			Ke-TL	suran	· ·		.1St (First, Middle	J	surance	2		
and	d be findal hed ot	Be	Edwin David	,						Ali		inna Kl		,			
5	2 should and Men is marke aumatic	မ	19a. Informant's Name/Rela				19b.	Mailing Add	ress (Street			I Route Numb			Zip Co	de)	
<u> </u>	and 2 ealth a n 27 is her trau		Michael H. He	rsch	man (so	on)	111	4 Som	erset	Plac	e. Lu	thervi	lle,	MD. 21	093	,	
ē,	- I 9 =		20a. Method of Disposition 1 ☐ Burial 2 🎖 Crema	ion o 🗆	Domousi from	State 20	b. Place of cemetery	Disposition crematory	Name of or other pla	ace)	D	ate	20c. Loc	ation - City o	r Town,	State	
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saitimore,	permit. Pages Department of Important; If It any injury or o		21. Signator of Firm ral Se	vice Liou		Coste:	r					k Tows			Hom	e,Inc	
	HH = # 6	17	23a. Part1. Enler the disease	e or com								r respiratory a		204	Ar	proximate	
	Dhamisian		shock, or heart failure. Immediate Cause (Final	List only	one cause on	each line.								1 >	Int	erval Betwo	
1	Physician /Medical		disease or condition resulting in death)		a. Due to	(or as a con	sequence *) e	025	1700	otic	ie Cu	ngo	I (Septe		Jea	rs
	Examiner		Conventially list conditions	-1	h												
7	P #	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	Que to	(or as a non	seque roe c).									
	ecute and I-trans	Examiner	that initiated events resulting in death) Last		c	(or as a con	o soneines	n·							-		
Ğ,	icate be executed physician and s the burial-transit			ı	,	(01 40 4 0011	sequenoe e	.,.									
09/89	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Medical			_ 0		-										
X R R	attendin for use		IF FEMALE: 23b. Was decedent pregnar		23c. If yes, or	utcome pf pre		3∏Ector	ic pregnanc	CV.			2	3d. Date of d	elivery		
	e dea he att	Physician/	in the past 12 months?			nant at time			r (specify) _		<u> </u>			Month	Da	y Ye	ear
J O	w requires that the d been signed by the should be detached	Phy	9 ☐ Unknown Part II. Other significant co	nditions	contributing to	death but not	resulting in	the underly	na cause di	ven in Part	1	23e Did	tobacco us	se contribute	to the c	ause of de	ath?
g,	signe d be d	d by	COVONA	4	Alter		ESC1		ng oudoo g	voi: iii i ari		12	/			y 4 <u>□</u> Ur	
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Ď T	The lar	Completed										auto perf	psy ormed?	prior to death?	compl	etion of cau	use of
Vital Records,		a	25. Was case referred to me	edical						26. Plac	ce of Death	1 Yes (Check only	2 ☑ No one)	1 □Ye	es 2L	No	·
	hysici his ce I direc	To B	examiner? 1 Yes 2 No		Hospital: 1] Inpatient	2 □ ER/Out	oatient 3[DOA Ot	her: 4 🗆 N	lursing Hon	ne 5∐Res	idence 6	Other (Sp	ecify) 🛭	4 ssis	ted
ם ס	Ing P			ending	(Mo	e of Injury nth, Day Yea	r) 28b. T	jury	28c. Inju			28d. Describe	how injury	occurred		FACILO	y,
<u> </u>	ttend death. stor: /	icati	3 Suicide 6 □ C	vestigation ould not b	e 290 Plac	e of injury - A	At home far	M m street fa		Yes 2		28f. Location	(Stroot and	Alumbarari	Duml D	nasta Alamah	
Division or	tal or A rs after ral Direct	Certification:	4 ☐ Homicide d	etermined	buil	ding, etc. (Sp	ecify)		ctory, office			City or To	wn, State)	Transer or r	nurar n	oute Numb	er,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical	29a. Certifier 1 ☐ Ce l (Check only 2 ☐ Me one)	tifying Ph dical Exa	nysician: To th miner: On the and ma	ne best of my basis of exar nner stated.	knowledge nination and	death occu	rred at the t ation, in my	time, date a opinion, de	and place, a eath occurr	and due to the ed at the time	cause(s) , date and	and manner a place, and d	as state ue to th	ed. e cause(s)	
	To t To t	M	29b. Signature and title of 9	ertifier	my	Al	y. 1	10		ise number			No c	e signed (Mon	nth, Day	v, Year)	306
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DH	MH 17 Rev 1/2	001			-												

State of Maryland / Department of Health and Mental Hygiene 38180 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2006 Year **Physician** 28. Nov. 7:18pm M Jean R. Burgan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Stella Maris Hospice Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F 216-03-1857 Director 95 May 8, 1911 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, the Medical Examiner must be notified at MD n/a Baltimore 1X Yes 2 No Director the 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code With or itema 23a or 4602 Parkwood Avenue 21206 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No tf Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Own Home 10th grade Home Maker s 1 and 2 should be filed v if Health and Mental Hygie Item 27 te marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Roney Jean McCubin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Hubert T. Burgan, Jr. 4602 Parkwood Avenue, Baltimore, Maryland 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Depertment of H Importent: If Ital 4 □ Donation 5 □ Other (Specify) Dec 1 2006 Baltimore, Maryland Holly Hill 21. Signature of Funeral Service Licens 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. un 6415 Belair Road, Baltimore, Maryland 21206 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** vance /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lue to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death φ in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Sunknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy certificate 2□ No 1 ☐ Yes 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4K Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 149 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No To the Hospitel or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) vember 7000 11/16 NE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD ERNESTINE WRIGHT, M.D.TIMONIUM MD21093 31. Date filed (Month, Day, Year) Registrar's Signature Registrar

DHMH 17 Rev 1/2001

NOVEMBER 28,2006

Baltimore,

Box 68760.

P.O. 1

Division of Vital Records,

BURGAN,

			1 - For State Registrar	State of M	aryland / D	epartme Certifica	ent of H	lealth a	and Me		giene Reg. No.	2006	38181
9	Physici	an	1. Decedent's Name (First, Middle, La	ast)					2	2. Date of Dea Month	ith Day	Year	3. Time of Death
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	Funeral Director		218-14-6503	1X M 2CTE		rs. Month		Hours	Min.	(Month, Day	, Year)	922	nplace (State or Foreign untry)
	De .		Usual Residence of Decedent										
	show	_	10a. State 10b. County		10c. City, Town								10d. Inside City Limits 1 X Yes 2 No
	be M	by Funeral Director	10e. Street and Number		Baltim								**
	with a or .	급					Zip Code 206					en of What Co	untry?
	heath ne 23	eral	3816 Bayonne Ave	12. Was Decedent	Ever in U.S.			isoanic Orio	gin? (Speci	ify Yes or No-	U.S	4. Race - Amer	rican Indian
က	or iter	Fun	1 Never Married 2 M Married	Armed Forces?					, Puerto Ri	fy Yes or No- ican, etc.)		Black, White	e, etc.
21215-0036	ral', c	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ∐ Yes	2 X No	Specify:				Specify: Whi	te
5	within 72 hours after death with the Maryland ene. then "netural", or iteme 23a or 28a-f show the Medical Exemiter must be cutillied at	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		Decedent's U Give kind of	work done	during most	t of working	7	16b. Kin	d of Business/l	ndustry
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an	d be Bental Ked o	To Be	Topos I as Pull Cm								Jamanoj		
Maryland	shou end M s mar umat	F	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Addre	ess (Street	and Numbe	er or Rural I	Route Numbe	r, City or	Town, State, Z	ip Code)
Ž	alth e		Mary Bull, wife		38	16 Bay	onne	Avenu	e, Ba	1timor	e, M	aryland	21206
ore	of He of Herr		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 (Domewal from State	20b. Pface of I		lame of		Dat			cation - City or 1	
Ĕ	Pag ment ant: h		4 □Donation 5 □Other (Spec		Parkw	ood Če	meter	y D	ec 1,	2006	Ba1	timore,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural; or iteme 23a or 28a-f show eny injury or other traumatic event. Ite Medical Examiner must be nutified at once.		21. Signature of Feneral Service Lice	900	>						-	Funera aryland	1 Home, Inc. 21206
			23a. Part1. Enter the disease, or shock, or heart failure.	one cause one	d the death. Do no	ot enter the m	ode of dyin	g, such as	cardiac or i	respiratory arr	rest,		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Finat disease or condition resulting in death)		a consequence of		Hear	+ 1)	lise a	156			Onset and Death In years
8760,	eath certificate be executed ettending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unesser or nury that initiated events resulting in death) Last	C	a consequence of								
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Division of Vital Records,	hes hes	Completed	. 3							24a. Was a autops perform	sy	24b. Were autoprior to codeath?	topsy findings available ompletion of cause of
ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					26. Pface	of Death /	Check only or			2.3.10
<u>></u>	S 50	၉	1 ☐ Yes 2 No	Hospitaf: 1 Inpati		patient 3	Oth	er: 4 🗆 Nu	rsing Home	5 A Reside	ence 6	□Other (Spec	erfy)
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DHMH 17 Rev 1/2001

	For State Registrar	State of Maryland		ent of Health ate of Death	1	giene 06	38182	
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Examiner	4a. Facility Name (If not institution, give HOWARD COUNTY GEN 5. Social Security Number 6. Se	ERAL HOSPITAL ox 7. Age (In yrs. la	HOI ast birthday) If Und	NARD CO.	of Death	4c. County of Death HOWARD 9. Births	place (State or Foreign	
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1 21215-0036 led within 72 hours all lygiene. ner then "naturel", or ner, the Medical Exem Completed by F	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12) 12 yrs.	ucation	life. DO NOT	work done during mos		16b. Kind of Business/In Medical In	dustry	
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the Head	19a. Informant's Name/Relationship (7 James H. Chaney (1) 20a. Method of Disposition	Son)	6800 Lir	nden Avenu		er, City or Town, State, Zip. Md. 21206 20c. Location - City or To		
Baltimore, permit. Pages 1 a Department of Hee Important: If Itam eny injury or othe	1√√3/8urial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen) Par	rkwood Cer 22. Name	netery	12~2~2006	Baltimore,		
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DIVISION Hospital or Attendit 44 hours after deeth. Funarel Director: Al tely tilled in by the tu		building, etc. (Specify))	City or Tox				
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To the within 2 within 2 complet	29b. Signature and title of certifier	my Coc M.		29c. License number		29d. Date signed (Month, Day, Year) NOV , 28 , 2006		
10	30. Name and address of person who of Kweku Hayt	completed cause of death (Item	23a) (Type, Print)	y Gener	ral Hospit	al		
State Registrar		32. gistrar's Signati		25				

Registrar

State

31. Date filed (Month,

11

1 2006 Page Strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Priph 6 Philase union 16 April Md 2123 A

Please Type or Print in Black Indelible Ink
Maryland / Department of Health and Mental H

James C. Cardw		1- For State	tate of Maryland	d / Depa	rtment o tificate o	f Health ar	nd Menta		20	06 3818
Physicia		Registrar 1. Decedent's Name (First, Midd	lle,Last)			Dodan		2. Date of Dea	ith	3 Time of Death
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aliticos.		St. Agnes Hospital	on, give street and numbe	er)		4b. City, Town, o Baltimore	or Location of D	eam	4c. County of n/a	Death
Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs. la	ast birthday)	If Under 1 Ye			rth(MM/DD/YYYY)	Birthplace (State or
Director		214-06-4227	1[X]M 2[F	40	Yrs	Months Da	ys Hours	May 1,	1966	Foreign Maryland Country)
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5-0036 Led within 7 Hygiene I other than	Completed	12	1		Accou	ntant			Medical	Supply
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2121 suld be fi Mental I marked	To Be	19a. Informant's Name/Relations	•		19b. Mailin	g Address (Stre		T. Schan		State Zip Code)
ore, MD 21215-0036 set 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene If item 27 is marked other than "matural". ther transuratic event, the Medical Examiner		Mary T. Cardwell / Mother 3900 Coolidge Avenue, Baltimore								
Baltimore, MD permit Pages I and 2 sh Department of Health ann Important: If item 27 is injury or other trauman		20a Method of Disposition 1 X Buriat 2 Crematio	n 3 Removal from S	State	rematory or ot			Date		ity or Town, State
Baltimore, permit Pages I an Department of He Important: If ite		Donation 5 Other S	pecify:	Lo	udon Pa	ark Ceme	tery 1	1/29/2006	Baltimo	re, Maryland
Bal permi Depar Impo		21. Signature of Funeral Service	licensee					Hubbard I		ome, Inc. aryland 21229
Physician		23a. Par I. Enter the disease, or failure. List only one cause	complications that cause	ed the death	Do not enter t	he mode of dying	, such as cardi	ac or respiratory arr	est, shock, or heart	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease		lerotic	cardiova	scular di	sease			Between Onset and Death
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6876 certificate nding phy	M/M	IF FEMALE. 23b Was decedent pregnant in the past 12 months?	23c. If yes, outo	ome of pregr		tal death 3	Ectopic pre	egnancy	23d. Date of de Month	elivery Day Year
atte	sician/M		4 Pregnant a	at time of dea	ath	her (Specify)				
T 0 2 0	Phy	Part II. Other significant condi	3 OTRITOWIT	ath but not re	sulting in the L	inderlying cause	given in Part I	23e. Did to	bacco use contribu	ite to the cause of death?
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Division of Vital Records, rat or attending Physician: The law requirers after cleath. al Director: After this certificate has been si led in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Cou	d not be	Injury - At ho	me, farm, stree	et, factory, office I	building, etc.	28f Location (S or Town, S		or Rural Route Number, City
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Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Finneral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	(Check only	hysician: To the best of miner: On the basis of ex	amination ar						
To To	Me	29b Signature and title of certific	and manner stated	//		29c. Licens	se number		29d Date signed	(Month, Day Year)
<u> </u>			NVI. 1/2	//		O.C.	M.E.		November 26	5, 2006
		30 Name and address of perfor Jack Titus MD. Dep	who completed cause of outy Chief Medical		,	in Street Pet	ltimore MD	21201	·	
St	ate	31. Date filed (Month, Day Year)		rar's Signatur		in Gireet, Dal	VIE, MD	Z 1 Z U I		
Posis		HEC 0	1 2006 482	200	A AR	SAL.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** 2:00 AM Davenport atricia 26 2006 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Overlea Hilton Rehab Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 217-40-5635 1 M 20€F Months Hours Maryland 62 Director July 12, 1944 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinating must be notified at 1 Yes 2 □ No Baltimore Funeral Director Battimore Maryland 10e, Street and Number 10g. Citizen of What Country? South 21231 Portferson Park Ave USA 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked 10 Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wanda Joseph Tirocchi Rakowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Airy Rd. Rosedale, MD 21237 Poliszuk / Mother 1407 Wanda 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State November 26,2000 Harrover, MD Anatomy Gliff's Registry 4 **⊠**Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Drive Suite P. Hanover, M.D. 21076 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one disease in each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (unas a consecuence off The law requires that the death certificate be executed attending physician and for use as the burial-trans Division of Vital Records, P.O. Box 68760、少 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📉 o 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 2□ No 1 Tes Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Other: Certification: To After this 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Direct 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and

Registrar

31. Date filed (Month, Day,

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32.

Registrar's Signature

Paven Blud Baltimore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Uvernber 29,2006 MILDRED DOUGLAS /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner naryland General Baltimore HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 □ M 2X F Director NOV. 25 1923 NORTH CAROLINA 220-30-6836 Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Director MARYLAND N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. death v 1412 ARYGLE AVENUE 21217 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status e filed within 72 hours after dal Hygiene. Black, White, etc. 1 ☐ Yes 2€ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XXNo Specify: BLACK ۵ 3\(\text{\text{Widowed}}\) 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE 6th grade PRIVATE d 2 should be filed w th and Mental Hygier 7 **is marked other tt** traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLIE SMITH FANNIE MOFFITT ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar ant: If item 27 is ury or other trau Celestine Douglas/Daughter 1412 Arygle Ave., Baltimore, Maryland 21217 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT CALVARY CEMETERY 12-05-06 GLEN BURNIE, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Mary Part1. Enter the disease, or complic shock, or heart failure. List only or Approximate Interval Between Onset and Death dions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, acuse on each line. mediate Cause (Final **Physician** disease or condition resulting in death) /Medical (u w or as a consequence of) **Examiner** 3 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-trai Due to (or as a conse attending physician IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Day 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) s after dea. 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide

Box 68760, P.0. Division or Vital Records, Hospitai

State

within 24 hours a

To the Funeral I

completely filled

To the

29a. Certifier

29b. Signature a

(Check only one)

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Registrar

Medical

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

NEutawst. Baltimore, MD 2120

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 0 0 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DILLARD 18.45 PM Physician KAE 200 6 ULIA /Medical 4c County of Death 4b. City, Town, or Locetion of Death 4a. Facility Name (If not institution, give street and number) **Examiner** WESTMINSTER CENTER HOSPITAL CARROLL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2X F 261-56-6223 67 4/21/1939 FLORIDA Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits with the Maryland 10b County 10a State rai', or iteme 23a or 28a-f ehow Examiner must be notified at 1 ☐ Yes 2X No NEW WINDSOR CARROLL MD Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number USA 21776 3234 ATLEE RIDGE RD. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: WHITE by 3 Widowed 4 Wivorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry The Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) SOCIAL WORKER MENTAL HEALTH 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental F Pages 1 and 2 should be EMMA HUNTER FRANK B. DILLARD 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SON f Health item 27 i 22 WEBSTER ST., WESTMINSTER, MD 21157 LARRY K. BLIZZARD, JR. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: if ite any injury or ot once. 1 ☐ Burial 2 Tremation 3 ☐ Removal from State ALL COUNTY CREMATION 11/30/06 SYKESVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Europial Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part it. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death RESPIRATORY FAILLIRE Immediate De se (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HEART (ONGESTIVE Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner FIBRILLATION ATRIAL or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. YPER TENSION Medical Certification: To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown HYPERCHOLESTEROLEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25 No HYPOKA LEMIA 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No After thi 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: Af investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospitei 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Dave signed (Month, Day, Year) 29c. License number 0005 858 0 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) BAI KANU. 3233 SUPERIOR LN. B21. BOWIE, MD 20715 31. Date filed (Month, Day, Year) State DEC 0.1 2006 Registrar

Registrar DHMH 17 Rev 1/2001 1 2006

State of Maryland / Department of Health and Mental Hygiene [] [] [For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Victoria R. Damico 11 29 2006 8:42p [™] /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Future Care Canton Harbor Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 5-27-1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F 89 Yrs. Director 214-03-7251 Maryland Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits or then "naturel", or Items 23a or 28a-f show the Medical Examinar must be notified at MD n/a Baltimore 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 308 S. Exeter Street 21202 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation

Other bind of work done during most of working Completed 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In own home 8th othert 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) å Mental Peter Cortezzo Anna Detorie 19a. Informant's Name/Relationship (Type, Print) Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health John Damico 308 S. Exeter St.Baltimore, Maryland 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. 1 ☐ Burial 2 MacCremation 3 ☐ Removal from State 12/4/2006 Baltimore, MD 4 □Donation 5 □Other (Specify) Greenmount -22. Name and Address of Facility Joseph N. Zannino Jr. FH 263 S. Conkling St. Baltimore, MD 21224 21. Signature of Funeral Service Licensee Meria sennero 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMUNARY **Physician** disease or condition resulting in death) EMBULLIM WEEKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). physicien and s the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 Yes 2 No P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DEMENTIA been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate hes t lirector, page 2 s perform 1 ☐ Yes 2 No 1 ☐ Yes 2 No of Vital After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one 1 Yes 2 No Other: 4 Jursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner eath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 Canatural s efter dea...ral Director: Afr 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide ŏ To the Hospital within 24 hours e To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Oay, Year) 2047945 WAD NOU 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 Au uns 031 PA PRIVE TOWERD WID 21204 CINAT 32 Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 1 2006 Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Patricia Ann Datta		State of Maryland / Department -For State Certificate		
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,Last) Patricia Ann Datta	<u> </u>	Reg. No. 2 Date of Death Month Day November 24, 2006 Reg. No. Year 1501 hrs
Medical Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	
		45 Glennwood Road #A	Essex	Baltimore County
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		Irs. 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Foreign Country) WVA
	E	Usual Residence of Decedent		
ow any		10a State 10b County 10c. City, Town or Lo	sex	10d. Inside City Limits
aryland 8a-f sh	Director	10e. Street and Number	10f. Zip Code	10g Citizen of What Country?
r death with the Maryland or items 23a or 28a-f show any must be notified at once,	١	45 A Glenwood Road	21221	USA
eath wit items 2	Funeral	1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puerl	to Rican, etc.) White, etc.
after d	by F.	3 Widowed 4 Divorced If Yes, 2 K No If Yes, Give Year of Dates:	Yes 2 XNo specify	Specify: White
2 hours "natur		Gallana (1.4 as 51)	dent's Usual Occupation (Give kind o g most of working life. DO NOT use re	
036 vithin 7 ene er than	Completed	9th	abled 	
	Be Co	17 Father's Name (First, Middle, Last) George Thomas		ne (First, Middle, Maiden Surname) t Shumate
D 212 should b and Meni 7 is marl	P	19a. Informant's Name/Relationship (Type, Print)	- '	r Rural Route Number, City or Town, State, Zip Code)
and 2 s lealth au tem 27	-	20a. Method of Disposition 20b. Place of Dis	position (Name of cemetery,	Date 20c Location - City or Town, State
TOFE Pages I ent of H nt: If i		Buildi 2 Pt Cleitlation 5 Removal non State	ew Crematory 1	1/29/06 Baltimore MD
Baltimore, permit Pages I ar Departament of He Important: If it	1	21 S / fature of Funeral Service Licensee 2		00 Mace Ave. Balto. MD
Physician	-1	23a Part I Enter the disease, or complications that caused the death. Do not ent	Connelly Fune: er the mode of dying, such as cardiac	
/Medical Examiner		failure List only one cause on each line. Immediate Cause (Final disease a. Bronchopneumonia and at	herosclerotic cardiov	Vascular disease Between Onset and Death Death
		or condition resulting in death) Due to (or as a consequence of):		
	iner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause		
√ 9. ¬ ≒	Examiner	(Disease or injury that initiated events resulting in death) Last		
executed an and al - transit	edical	T UNPENDED X AMENDED		
760, cate be exc physician the burial	/Med	X UNPENDED #2 23a 27 perME 9865 IF FEMALE: 23b. Was decedent pregnant in the		23d Date of delivery
× 6876 h certificate tending phy use as the	sician/M	past 12 months? 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregr Other (Specify)	nancy Month Day Year
the ed a	3	1 Yes 2 ✓ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?
of Vital Records, P.O. ing Physician: The law requires that th After this certificate has been signed by uneral director, page 2 should be detach	þ		te driderlying educe given in a dri	1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirs after death "al Director: After this certificate has been seen in by the funeral director, page 2 should	Completed			24a Was an 24b. Were autopsy findings available prior to completion of cause of
Recc The lav icate ha	E C			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Rec ysician: The I his certificate b director, page	o Be	25 Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other Nurs	k only one) sing Home 5 Residence 6 ✔ Other Scene
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ivision For Attendi after death Director: d in by the f	catio	1 X Natural 5 Pending 2 Accident Investigation 28e Place of Injury - At home, farm, s	1 Yes 2 No	28f. Location (Street and Number or Rural Route Number, City
Divisior pital or Attencours after death eral Director:	Certification:	Suicide 6 Could not be determined (Specify)	areet, ractory, office building, etc.	or Town, State)
Divisior To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the		29a Certifier (Check only) Certifying Physician: To the best of my knowledge, death or		
To the within To the comple	Medical	2 Medical Examiner: On the basis of examination and/or invest and manner stated 29b Signature and title of certifier	29c License number	29d. Date signed (Month, Day, Year)
		Marine me Marle	O.C.M.E.	November 25, 2006
	ŀ	30 Name and address of person who completed cause of death (Item 23a) Maggarita Koroll MD Assistant Modical Examinar 111	Pann Street Baltimore ME	21201
Ø Ste	ate		Penn Street, Baltimore, MD	7.2.12.0.1
Registi	rar	31. Date filed (Month, Day, Year) DEC 0 1 2006 32. Rej Strar's Signature	goods.	

Time of Death

en Onset and

Year

Death

2350 hrs

To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O.

Completed			24a. Was an autopsy performed?	24b Were autopsy findings availab prior to completion of cause of death? 1 Yes 2 No							
0	25. Was case referred to medical	26.Place of Death (Ched	ck only one)								
9 0	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 ✓ Other: Scene									
cation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	ijury 28c. Injury at Work?									
ertifica	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, stree (Specify)	t, factory, office building, etc.	28f. Location (Street and or Town, State)	28f. Location (Street and Number or Rural Route Number, Ci or Town, State)							
Medical	29a. Certifier (Check only one) 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated										
' Š	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)							
		O.C.M.E.	Octol	per 29, 2006							
State	30. Name and ad le's of pirso who completed cause of death (Item 23a) Mary G. Ropple MD. Deputy Chief Medical Examiner 111 31. Date filed (Month, Day, Year) 32. Registrar's Standard	Penn Street, Baltimore,	MD 21201								

Registrar

DEC 0 1 2006

				Amend Item 23aPtI per ME CB State of Mary State Amend item#25, 27, 28a-f, per Registrar	2.12/01/06 land / Depa	intment of H	ealth and N	lental Hy	giene	106	3819	2
		•	•	State Amend Item#25, 27, 28a-1, per Registrar	ME, Gooder	tificate of t	Death			100	0012	las-
		Division		1. Decedent's Name (First, Middle, Last)				2. Date of De Month	aath Day	Year	3. Time of Deat	
		Physici /Medio		Ruth Adelaide Ehrhardt				Nov.		006	15:20	М
		Examir		la. Facility Name (If not institution, give street and number)		-	Location of Death			nty of Death		
				Upper Chesapeake Medical Cent		Bel Air	If Under 24 Hrs.	R Date of Bir		rford	along (State or For	roian
		Funeral		4 D M 2005	yrs. last birthday).	Months Days	Hours Min.	8. Date of Bir (Month, Da	27,1917	Nota	place (State or For intry) York	eigii
		Director		Usual Residence of Decedent	,,			100. 2		11011	1011	
		yłand			c. City, Town or Lo						10d. Inside City Lin	
		Mar.	ctor	Maryland Cecil	Elkton						1 Tes 2 🔀	LNo
		be tiled within 72 hours after deeth with the Maryland tal Hygiene. Ind cher than "natural", or iteme 23a or 28a-f show event, the Medical Examinar must be notified at	ai Director	10e. Street and Number 250 Greenwood St.		10f. Zip Code	21921		10g. Citizen	of What Cou	untry? USA	
		deet	Funerai	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp	ecity Yes or No	D- 14. F	Race - Amer Black, White		
	ဖွ	or ite	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No		I ☐ Yes 2 █ No		, , ,	1		hite	
	93	72 hours after natural; or ite	d by	3 ₩idowed 4 Divorced Year or Dates:								
	5-0	nati	ete	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupa kind of work done of OO NOT use retired	during most of work	king	16b. Kind o	f Business/I	ndustry	
9	121	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		maker	"/		Омло	Home		
Q	d 2	e filed withi Il Hygiene. other than vent, the M	ပို	17. Father's Name (First, Middle, Last)	1101110		18. Mother's Nam	e (First, Middle	1			
11-10-06	an	Mental Mental arked c	To Be	Henry George Steinmetz			Adelaid	e A.	Diehl			
=	Maryland 21215-0036	2 should and Men is marke aumatic	-	19a. Informant's Name/Relationship (Type, Print)		g Address (Street	and Number or Ru	ral Route Numb	er, City or To			
	-	s 1 end 2 should f Health and Mer item 27 is marke other traumatic		Sandra Ruth Evans - daughter		Beckett (_			
0	ore		6.3	1 Rurial & Cremation & Removal from State		natory or other plac	(8)	Date	20c. Location	-		
76	Ĕ	Pag ment ant: I		4 □Donation 5 □ Other (Specify)	Hilltop S	Services (14-06	Towson	, Mar	yland	
215114	Baltimore,	permit. Page Department of Important: If any injury or once.	I	21. Signature of Funeral Service/Licensee/		. Home aryla	, P.A. nd 21009					
5		To the		23a. P.v.1. Inter the disease, in complications that caused the shinck, or heart failure. List only one cause on eight line.	death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between	
4	,	Physician		Immediate Cause (Final disease or condition	hal h	emorr	have				Onset and Death	-
100		/Medical Examiner		resulting in death) Due to (or as a co	onsequence of):	0 -	, 8				1	
M8cc	-	Examine		Sequentially list conditions,	rat (onlusu	nu		. / /		days	-
80		bed isit	ig e	cause. Enter Underlying Cause (Disease or injury	lisequence cij.	(150)	<i>T</i> ₀	A A	1//	2	mitt	_
-		be executed sicien and burial-transit	Examiner	that initiated events c. Due to (or as a co	insequence of):	a inw		AN S	MCAL PRAMIN		7730-010	-
	760,	e be e	cal	d			-	OVEDBY	C./.			
7	99	leath certificate be attending physic	edi				CERTIFICATION					
T	ŏ	h cert endin	S	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □		Ectopic pregnancy	,		23d.	Date of deli		
C V	8	deat ne att	Physician/Medl	in the past 12 months? 1 Yes 2 No 4 Pregnant at tim		Other (specify)				Month	Day Year	
7	P.0	that the d ed by the deteched	Ę,	9 Unknown				nn- Did		antelbuda ta	the source of death	.2
+		res tha iigned l be det	ğ	Part II. Other significant conditions contributing to death but n	matord	-			Yes 2□N		the cause of death bably 4 Wunkn	
2	ord	w require been si should b	ted	Hyperlension, Kheir	majore	arma	les .	+				
Ehrhandt	Records,	hes b	Completed	0.					s an 24 opsy formed?	4b. Were au prior to d death?	topsy findings avail completion of cause	able of
4		ding Physicien: The	ပ္ပ					1 □ Yes	200 No	1 Yes	2□ No	
17	Vital	icien Sertifi ector	Be	25. Was case referred to medical examiner?		oth Oth	26. Place of Dea	- 1				_
	ot	Phys this ral dir	12	1 Yes ZANO 1 Inpatient	2 ER/Outpatier	11 3LI DUA	4 Nuising n	ome 5 Res			cify)	
	U	ding h. After fune	ti O	27. Manner of Death Chatural 2 Accident 28a. Date of Injury (Month, Day Yes)	6:00 ar	Wor	k? Yes 2.∏nNo					
	Division of	deat deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury	- At home, farm, str	11	Λ	subject 28f Location	(Street and N	umber or Ru	ral Route Number,	
	Ö	after i Dire	Certification:	4 Homicide determined building, etc. 73	Specify)			Bel Air		309 Bed	kett Court	
		To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending physicompletely filled in by the funeral director, page 2 should be deteched for use as the I	edicai (29a. Certifier (Check only one) 1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of example and manner stated	amination and/or in	vestigation, in my o	pinion, death occu	, and due to the rred at the time	e cause(s) and , date and pla	ce, and due	to the cause(s)	
		o the	Med	29b. Signature and title of certifier		29c. Licens	e number		29d. Date si	gned (Monti	n, Day, Year)	
		- 3 + 5		> aller I	m.D.	D	0018	779	Nama	Man	10 200	56
		10)		30. Name and address of person who completed cause of deat	h (Item 23a) (Type,	Print)	^		/ voven	-ve 2	-, a - c	
	E			ALBERT S. SUN, M.D. 1.	716 Har	ford Ro.	ad, Suit	te 105,	Falls	ston	n, Day, Year) 10, 200 MD 210	4'
	F 7		tate	31. Date filed (Month, Day, Year) 32. Registrar's	Signature	ands)						
		Regis	trar	NOV 2 2 2006 LANGE	July Park	Series .						

		1 - State Americal Item 2	State of Maryland Sa per dr., 0362, I	2/01/206	idment of F dip tificate of	lealth and Death	Mental Hyg	giene 006	3819		
Physici	20	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	/ Day Year	3. Time of Death		
/Medic		MYRTLE FRANZE					Novem		60 P		
Examin	er	4a. Facility Name (If not institution, give : Maryland Grene	Ral HOSPT	tal	Baltin	ORC C	THY	4c. County of Dea			
Funeral Director		5. Social Security Number 220–26–8695 Usual Residence of Decedent	7. Age (In yrs. In X	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1931 MA	rthplace (State or Fore ountry) RYLAND		
* ==		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Lim		
	ō	MD. N/A	R	ALTIMO	RE				1 X Yes 2 □		
288	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?		
38.0		1743 N. CAREY S	ST.		2121	7		USA			
el', or items 23a or 28a-f show Exercitat nevat be notified at	y Funeral	1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give	1	Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 ☒ No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	ite, etc.		
"naturel", edical Ex	ted by	3 XWidowed 4 ☐ Divorced 15. Decedent's Edu		16a. Dece	tent's Usual Occur	pation	4/10	16b. Kind of Business	s/Industry		
_ C	Completed	(Specify only highest grade Elementary/Secondary (0-12) -12-	College (1-4or 5+) -()-	life.	kind of work done DO NOT use retire SSING GUA	d)	rking				
D =		17. Father's Name (First, Middle, Last)	_0_	CRUS	SING GUA		me (First, Middle.	BALTO. PO Maiden Sumame)	LICE DEPI		
E o y	To Be	BENJAMIN HULL					G. BAILE				
and Men is marke eumatic	Γ.	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street	and Number or R	ural Route Numbe	ar, City or Town, State,	Zip Code) 3224		
Department of Health and Mer Important: If Item 27 is marks eny injury or other treumatic QDGB.		LENORA PURDIE (I 20a. Method of Disposition 1 Burial 2 Cremation 3 P 4 Donation 5 Other (Specify)	emoval from State	lace of Dispo emetery, crei LISON I	sition (Name of matory or other pla FOREST VE	TERANS 1	Date 1-22-200	JACKSONVIL 20c. Location - City o 6 OWINGS M UNERAL HOM	r Town, State		
Departm Importate eny inju		21. Signature Tuneral Service Licens 23a. Part1. Enter the disease, or complete). Hus	1	721–27 N	. MONROE	ST. BAL	TIMORE, MA	12.17.5		
hysician /Medical xaminer	er.	shock, wheart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of): Hypertension								
ste has been signed by the ettending physicien and bege 2 should be detached for use es the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				ic Shock glycenia					
ed by the ettending p detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de	egnancy 23d. Date of delivery Month Da			alivery Day Year				
n signed build be deta	Part is, other significant conditions continuously to death but not resulting in the underlying cause given in Part is								acco use contribute to the cause of death		
	Completed							rmed? death?	utopsy findings avail completion of cause s 2 \(\text{\tint{\text{\text{\text{\text{\text{\text{\text{\tint{\text{\tin\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texit{\text{\tex{\texi{\text{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\teti}\text{\texi}\text{\texit{\texi{\texi{\texi{\texi{\texi{\		
this certificete	Be	25. Was case referred to medical examiner?	lospital:	ED/C :	. aca aca i Ott	ner	ath Check only o				
ath. r: After this e funeral di	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Inju	4 🗆 Nursing i	,	dence 6 Other (Sp.	ecity)		
within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, sti	eet, factory, office		28f. Location (S City or Tox	Street and Number or F vn, State)	Rural Route Number,		
within 24 hours e To the Funeral C completely filled	Medical C	29a. Certifier 1 Certifying Phy (Chack only one)	rician: To the bast of my kno ner: On the basis of examinal and manner stated.	wledge, deet tion and/or in	h occurred at the ti vestigation, in my o	ma date and plac opinion, death occ	a and due to the urred at the time,	nause(s) and manner a date and place, and du	is stated ie to the cause(s)		
To th	M	29b. Signature and title of certifier	Inheni	,	29c. Licens			29d. Date signed (Mor			
0)		30. Name and address of person who co	empleted cause of death (Item Lateneva	23a) (Type,	Print) 4 p	Parula	nd Gi	11/16/04 eneral k	lospita		
St: Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per ME, G861/11/29/06dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Freeman Year Delmar 2330 PM Krember 16 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bathmore Johns Hopkins Bery view Modical
5. Social Security Number 6. Sex 7. Age (In yrs. In If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days **★**→ 2□ F 45 Director 219 80 5568 Usual Residence of Decedent JAN. 22,1961 MD. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at Director MD. N/A BALTIMORE tv☐Yes 2☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 3605 e. FAYETTE ST. 21224 Itеme 23a USA 2 should be filed within 72 hours after death is and Mental Hygiene. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) YEARS COOK RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LINWOOD FREEMAN, SR. permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic evonce. RUTH THORNTON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNETTE MARABLE(fiance) 3605 E. FAYETTE ST. BALTO, MD. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State MT.ZION CEM. NOV.22,2006 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): ancreatitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine VEHI FICATION APPROVED BY Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation I Director: A id in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. within 24 hours efter of To the Funeral Direct completely filled in by

the Maryland

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

Adam

2 9 2006

31. Date filed (Month, Day, Year)

4940

MD

32. Registrar's Signature

asones 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSSMEN

29c. License number

Avenue

29d. Date signed (Month, Day, Year)

06-08975 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Robert Floyd 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day November 25, 2006 Year **Medical Examiner** Robert Patrick Floyd, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Director Hours 144-24-5112 1 X M 2 76 Yrs Country) NJ F 11/01/1930 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location s 23a or 28a-f show a notified at once. PA Delaware Wayne Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' 26 Greythorne Woods Circle 19087 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married 2 1 X Yes White Yes, Give Year or Dates: Divorced 1951-53 Yes 2 X No specify. Specify þ 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 hours 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene tant: If item 27 is marked other than "or other traumatic event, the Medical. MD 21215-0036 Human Resources Executive Safeguard Scientifics 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Robert P. Floyd, Sr. Kathryn McCullough ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexandra Floyd - Wife 26 Greythorne Woods Circle, Wayne, PA 19087 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State important: 12/01/2006 Yeadon, PA Holy Cross Cemetery ognature of Funerall Service bicenses 22. Name and Address of Facility 401 S. Chester St. David J. Weber F.H. Baltimore, MD 21231 Part I. Enter le e, disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. /Medical a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 1 per me 9862 12-1-06 vt UNPENDED Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Dav past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Cirrhosis Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? ✓ Yes 2 1 🗸 Yes No To the Hospital or Attending Physician: 25 Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Other Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 DOA 1 🗸 Yes 27. Manner of Death 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Pending Director: Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined (Specify) To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

0646 hrs

10d Inside City Limits

1 X Yes 2 No

Approximate Interval Between Onset and

Death

Year

2 No

29d Date signed (Month, Day, Year)

November 25, 2006

31 Date filed (Month, Day, Year, UEC State Registra

29b. Signature and title of certifier

Jack Titus MD.

Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 egistrar's Signature

ORIGINAL

29c. License number

O.C.M.E

and manner stated

30 Name and address of person who completed cause of death (Item 23a)

Amend Item 23a 111 per M. 302, 12/01/00000 Ensure All Copies Are Legible. Amend Items 18,25,27 per FH/Dr Cortificate of Death and Mental Hygieng 0 0 6 1 = For A State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 10 22 2006 1:00 AM /Medical Deborah Veronica Gross 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 319 Ponfield Road - West Forest Hill Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/07/1956 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F Months Yrs. Director 50 Maryland 218-68-2697 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or itams 23s or 28s-f ahovent, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 319 Ponfield Road - West 21050 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Hair Dresser **Hair Fantasy** 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Be Mental Evelyn Veronica Doster 1 and 2 should be is marked 2 Thomas Tiletsky Eveltn Veronica Doster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21050 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tra 319 Ponfield Road - West - Forest Hill, Maryland Gary Gross (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 Nother (Specify) Mausoleum Parkwood Cemetery 10/26/2006 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland aa 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** monar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER physicien and the burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical ettending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, ģ Ian 4 Unknown 1 Yes 2 No 3 Probably certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 🗌 Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one | examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No ۵ 2 ER/Outpatient 3 DOA ŏ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division After or Attending 5 Pending investigation 1X Natural s effer dec. 1 ☐ Yes 2 ☐ No 2 Accident determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours of To the Funaral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check on title of certifier 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 6444 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. Atwood Rd. Belair 21047 602

Registrar

State

31. Date filed (Month, Day, Year)

MOV 2 9 2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 15 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** LUCILLE GASKILL November **GLORTA** 28, 2006 11:28 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Manor Care of Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Washington, DC 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 231-52-6181 Sept 6, 1940 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2☐No notified Director Maryland Prince George's Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 9000 Briarcroft Lane 20708 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2X☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2XXNo 1 ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 Specify: Specify: Completed by 3¥Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grade 10 Nurse Assistant Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any linjury or other traumatic evone. Rosa Lee Craddock (unknown) ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angella L. Wright daughter 12905 Laurel-Bowie Road #201 Laurel, Maryland 20708 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State West Arundel Crem. 11/30/2006 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or compshock, or heart failure. List only Approximate Interval Between Onset and Death ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Immediate Cause (Final Valvular heart Severe **Physician** unknowin disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 4□Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 X No 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Congestive Heart Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Anemia Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Box 68760, P.0. Records, Division or Vital To the Hospital or Attending death. Director:

To the Funeral

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 29a. Certifier Medical

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Chowdly, mi) 29c. License number D43/21 29d. Date signed (Month, Day, Year)

20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NURUL CHOWDHURY, MD; 15216 DINO DRIVE; BURTONSVILLE, MD 20866

Registrar

31. Date filed (Month, Day, Year)

DEC 0 1 2006



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2006 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Brenda Ann Hyman November 30 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist HOSPICE Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 214-62-9479 Director Vicquala February 11, 1954 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1700 N. Gay Street 21213 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own HOME traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event Be Hyman Unknown Jessie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 9593 N. Hany Drive # 202 Manassas, VA 20110 Damon Johnson Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Androny Bifts Registry Nevember 30,2000 Harries, MID

22. Name and address of acility Anatomy Gifts Registry 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 7522 Connelley Drive suite P. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SHOWLY **Physician** DAYS /Medical Due to (or as a consequence of): Examiner endocarditis pacterial wedes Sequentially list conditions, if any least term to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner SUDSTANCE physician and s the burial-trans Complications Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical SB attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 Yes 2 No certificate has been 24a. Was an autopsy performed?
1□ Yes 2 200 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide o the Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nevember 30 2005 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Sr DAZMINE NO ZIZOT Amon 6601 N. Charles no 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Good

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ameni Item 21b per M. G62, 1/01/01b

State of Maryland / Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene Department of Health and Mental Hygiene Certificate of Death Amend Items 23a, b Pt 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Detober 11/16 18 7006 /Medical 4b. City, 4a. Facility Name (If not institution, give street and number, Town, or Location of Death Examiner 4c. County of Death BALFIMOLE If Under 1 Year | If Under 24 Hrs. HOPKin HOSPITAI Johns 8. Date of Birth (Month, Day, Year) 11/23/1963 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 417-96-4453 Vrs AL Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28e-f ehow other traumatic event, the Medical Examiner must be notified at Scottsboro ALJackson 1 Tyes XN No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or 2840 County Road 138 35768 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 end 2 should be filled within 72 hours after c Department of Heelth and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Examinary once. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes X☐ No Specify: Specify: Š 3 ☐ Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Smith Bertha Harrison Merle ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha Smith / Mother 289 Sleepy Lane, Woodvile, AL 35776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/27/2006 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Skyline Cemetery Skyline, AL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 Us U 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE **Physician** CETTER PORT OFFI /Medical Due to (or as a consequence of): Examiner Tylenol Use Sequentially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last D e to (or as a consequence of): Examine or Attending Physician: The law requires thet the death certificate be executed Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cete hes been sign. , page 2 should be 24 No 3 Probably 4 Unknown Alcohol Use 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Depatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 212 No 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred Unknown 27. Manne f Death 28c. Injury at Work? 28b. Time of Cown After 5 Pending 1 ☐ Yes 2 ☐ ₩o death. 2 Accident investigation 81. Loca ion Street and Number or Rural Route Number, City or Town, State) within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 - Homicide Unknown Unknown Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) ES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Senter Shawn 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 0 6 38200 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 11/21/2006 Year Richard Hanchett 10:00₽ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 **3€**M 2 □ F 492-48-4237 60 Yrs. Director 11/7/1946 TT. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Health and Mental Hygiene. Item 27 ie marked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, tra Medical Examinar must be notified at MD Carroll Westminster 1 TYPes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3451 Uniontown Road 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 EYes 2 No If Yes, Give 1 9 69–1972 Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) Commercial Photographer Advertising 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Hanchett Francis Dorothy Marie Irland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1317 Whitney Lane, Rolla, MO 65401 19a. Informant's Name/Relationship (Type, Print) Shari Dunn-Norman /Daughter-in Pages 1 and 2 nent of Health a 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cremation Society Of St. Louis ö 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/1/2006 permit. Page Department of Important: If eny injury or once. St. Louis, MO 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore, MD 21230 21. Signature of Funeral Service Licensee Marist W 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Severe Cardiomypathy 6 years /Medical Due to (or as a consequence of) Examiner Non Q Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). physicien and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical as the use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? ō Month Dav Year 5 ☐ Other (specify) signed by the aid d be detached for 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, DM, Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☑nknown Should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☑ No 24a. Was an page 2 s has performed? certificate 1 ☐ Yes 2 No or Attending Physician: director, To Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: , completely filled in by the f 2 Accident 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge identifications and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number elo D 52035 November 29th, 2006 (30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chacko M.D. 291 Stoner Avenue, Westminster, MD 21157 32. Aggistrar's Signature 31. Date filed (Month Bar Year) State Registrar

DHMH 17 Rev 1/2001

06-08896 Ronnie Hall Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar	Re	g. No. 200	6 3820
Physician	1/	Decedent's Name (First, Middle,Last)	Date of Deat Month		3. Time of Death
Medical Examin			Month November		1919 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death St. Agnes Hospital Baltimore		4c. County of Deat	n
Funeral			8. Date of Birt	h(MM/DD/YYYY) 9. Bi	rthplace (State or
Director	-	243-92-1461 1XM 2 F 53 Yrs. Months Days Hours Min.	O(TI 23	7, 1953 Forei	gn Puntry) NC
	ŀ	Usual Residence of Decedent	001 23	7 1995	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
v any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
.faryland 28a-f show 1 at once	ğ	MD BALTIMORE			1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 10f. Zip Code	110	lg, Citizen of What Cou	intry'?
5-0036 led within 72 hours after death with the Maryland thygiene other than "natural", or items 23a or 28a-f shother than "natural", or items 21a or 28a-f shother than "natural".	ᇛ	4410 PARKTON ST. 21229 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec		USA	ican Indian, Black,
ath w items	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rie		White, etc.	toan indian, black,
fter de				Specify: BL	ACK
5-0036 led within 72 hours after tygiene "natural", other than "natural", the Medical Examiner	Completed by	15. Decedent's Education (Specify only highest grade completed) 15a. Decedent's Usual Occupation (Give kind of wor during most of working life. DO NOT use retired		16b. Kind of Business	
6 172 h an "n	e e	Elementary/Secondary (0-12) College (1-4 or 5+)	a),		
21215-0036 uld be filed within 7 Mental Hygiene Hagine c event, the Medica		12TH CUSTODIAL 17 Father's Name (First, Middle, Last) 18 Mother's Name (F	iret Middle A	STADIUM	S
115-	BeC			,	
2121 uld be f Mental markec c event,		STACY HALL STACY HALL 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run			e, Zip Code)
	Ŧ		TIMORE	, MD 2122	9
re, MC 1 and 2 sl 1 Health ar 1 fitem 27 er trauma		20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	Town, State
Baltimore, permit Pages I ar Department of Hes Important: If ite	J	4 Donation 5 Other Specify. CROWNSVILLE 11/2	6/06	CROWNSVI	LLE, MD
Baltimo permit Page Department Important: injury or ot	Ĩ	21. Signature of Funer - ervice Licen - 22. Name and Address of Facility WESI	LEY CHA		
	4	23a Par I. Enter the direction of the death	Æ., BA	LTIMORE, M	D 21231 Approximate Interval
Physician /Medical		failure. List only one lause on each line.	ospiratory arre	sat, anock, of near	Between Onset and Death
Examiner	Ì	Immediate Cause (Final disease or condition resulting in death) a. Head Injuries Due to (or as a consequence of):			35001
7		Sequentially list conditions, b.			
	je	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			1
xecuted n and l-transit					
e be exysician	훓ᆫ	UNPENDED AMENDED			
8760, ificate by ug physic	Ž	23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	:y	23d. Date of deliver Month	y Day Year
Box 687 ne death certification the attending led for use as t	icia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
Bone dea	Physician/Medical	1 Yes 2 No 9 Unknown 9 Unknown	22a Did to	bacco use contribute to	the save of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. The law requires that the safter this certificate has been signed by all Director: After this certificate has been signed by led in by the funeral director, page 2 should be deated.	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		2 ✓ No 3 Pro	
ords, Fw requires	Completed by		24a. Was a		utopsy findings available
COrc	립		autop: perfor	med? death?	completion of cause of
tal Rec	ટૅ	25. Was case referred to medical 26 Place of Death (Check onl	1 Yes	2 No 1 Y	es 2 No
Vital ysician his cert directo	B	examiner?		Residence 6 Othe	r:
ing Phy After th	입	1 V res 2 No	Bd. Describe h	now injury occurred	
Sion Attendin r death ector: A	흲	1 Natural 5 Pending Nov 22, 2006 0000 hrs 1 Yes 2 No St	ubject fell		
ViSi or Att or Att or Att or Att	<u>i</u>	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28	Bf. Location (S or Town, S		ural Route Number, City
Div Hospital o 24 hours af Funeral D	Certification:	4 Homicide determined (Specify) Sidewalk	110 Parkton	Street, Baltimore, M	D
To the within To the complet	Medical	and manner stated. 29b Signature and title of certifier 29c License number		29d Date signed (Mo	
		10 ha Me ex QIA O.C.M.E.		November 23, 2	• • • • • • • • • • • • • • • • • • • •
		30. Name and address of person who completed cause of death (Item 23a)			
7		Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201		
Sta		e 31 Date filed (Month, Day, Year) 32 degistrar's Signature			
Registr	rar	BEC 0 1 2006 Minus & Joseph			
DHMH 17 Rev 1/20	01	ORIGINAL			

OCME 2006

State of Maryland / Department of Health and Mental Hygiene? [] [] 5 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** RAYMOND HIRONS 0006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kosedale uare If Under 24 Hrs. tf Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours 1 √ M 2 □ F 219 07 8101 Director 85 02-06-1921 CANADA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Heatih and Mental Hygiene.

It of Heatih and Mental Hygiene.

It is marked other then "naturel", or itema 23a or 28a-1 show or other traumatic event, it a Medical Exam an must be notified at 1 Yes a No MD BALTIMORE MIDDLE RIVER Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 46 D OAK GROVE DR. 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 GYes 2 □ No tt Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: ģ 3 ☐Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 PLUMBER COMMERCIAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be JOHN HIRONS DOROTHY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES KELLY/NEPHEW 3537 BAY DR. MIDDLE RIVER, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its:
any injury or ott Baltimor 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 12-04-2006 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service License 1211 CHESACO AVE., ROSEDALE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons equence of): Examine burial-transit or Attending Physicien: The law requires that the death certiticate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical ned by the attending physical detached for use as the IF FEMALE: 23c. tf yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use, contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 24 No 1 Inpatient ဥ 2 ER/Outpatient 3 DOA After this 27. Manufer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how intury occurred Certification: 1 Naturat 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Ptace of tniury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ES BRADA address of person who completed cause of death (ttem 23a) (Type, Print) baltimore, md Eaddi 9000 Franklin Square 32. Registrar's Signature 31. Date fited (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 38203

			1 - State Registrar			Ce	rtificate of	Death	2110 1110	ritar i iyg	eg. No.		
	Physici	an.	Decedent's Name (First, Midd						1	2. Date of Deal		Year	3. Time of Death
	Physici /Medio		Paul Stanley I							Novemb	er 25,	2006	11:25 PMM
	Examir	ner	4a. Facility Name (If not institution 4837 Wright Av	-	er)		4b. City, Town,	or Location o Balti			4c. County of De Baltimo:		City
	Funeral Director		5. Social Security Number 237-40-5958	6. Sex 7.	Age (In yrs. Ia 75	ast birthday) Yrs.	If Under 1 Year Months Days	If Under		B. Date of Birth (Month, Day 03/30/			lace (State or Foreign
	ס		Usuel Residence of Decedent										
	•how	5	MD Balt			,Town or Lo Ltimor						1	0d. Inside City Limits 1. Yes 2 □ No
	the M	Director	10e. Street and Number	imore City	Bal	LCIMOR	10f, Zip Code			1	On Citizen	of What Coun	
	h with	ai Di	4837 Wright Av	renue			21205			10g. Citizen of What Country USA			iu y :
	r dea	Funerai	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S	S. 13.	Was Decedent of I	Hispanic Original	gin? (Spec	Specify Yes or No- to Rican, etc.) 14. Race - Black,			
036	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-1 ehow ta Madical Examinar must be notified at	b	1 Never Married 2 Ma 3 Widowed 4 Divorce		⊒No s: 1950-		1□Yes 2MNo				1	^{cify:} W hit	
ν Ο	72 ho	etec	15. Decede (Specify only highe	nt's Education est grade completed)		16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most	t of working	g	16b. Kind of	Business/Inc	dustry
7	within lene. then	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)		DO NOT use retire trician	ed)			Comme	ICIAI	
and 2	ould be filed v Mental Hygie varked other i satic event, th	Be	17. Father's Name (First, Middle Saint Elmo Hol						r's Name ((First, Middle, M	Maiden Sum	ame)	· · · · · · · · · · · · · · · · · · ·
Maryland 21215-0036	2 sh and is m	2	19a. Informant's Name/Relation Linda Patton/Da		, , , , , , , , , , , , , , , , , , ,		ng Address (Street						
	tond Health tem 27 other to		20a. Method of Disposition			ace of Dispo	sition (Name of	Ī	Da			n - City or To	
altimore,	Pages ment of I tent: If Its		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Chesapeake Crematory 11.27.06 Be Cremation and Address of Facility Cremation and Funeral Alternation								Beltsv	eltsville, Maryland	
Ball	permit. Departr Importe any inji		21. Signature of Funeral Service	Ricensee	10144	3 2	Name and Addre Cremation 3717 Green	ss of Facility and Fu	neral res D	Alterna	atives altimo	re, Mar	vland
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cause tonly one cause on each	sed the death								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		010	Ina.	ma	Af,	Win	16			Opent and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	ience of):							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequ	ience of):							
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68760,	death certificate be executed e attending physician and id for use as the burial-transit	al Ex	resulting in death) Last	Due to (or	as a consequ	uence of):							
	nificate ng phy as the	Medical	IF FEMALE:	U							1		
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o.	0 0	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant 9☐ Unknown	at time of de	eath 5	Other (specify) _						
S, G	The law requires that the ate has been signed by thoage 2 should be detache	by PI	Part II. Other significant condit	ions contributing to death	n but not resu	Iting in the u	nderlying cause given	ven in Part I.		23e. Did tob	acco use co	ontribute to the	e cause of death?
ord d	w require been signature	ted								1 □ Ye	s 2 No	3∏ Proba	ably 4 Junknown
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<u>=</u>	Physicia this cert al direct	To Be	examiner? 1 ☐ Yes 2 D No	Hospital: 1 ☐ Inpa	atient 2 🗆 E	ER/Outpatien	t 3 DOA Ott			Check only on 9 5 eside		ther (Specify	1
<u>0</u>	ng Phys fter this ineral di		27. Manny of Death 1 Matural 5 ☐ Pendi	28a. Date of Ir		28b. Time of Injury				d. Describe ho			/
Division of	or Attending Physician: after death. Director: After this certifici in by the funeral director.	cati		igation			M 1	Yes 2 □ 1					
Σ	el or Attendest s after desti nl Director: ed in by the	Certification:	4 ☐ Homicide determ	mined 286. Place of	etc. (Specify)	me, tarm, str	eet, factory, office		28	City or Town	reet and Nui , State)	nber or Hural	Route Number,
	To the Hoepitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physician: To the be I Examiner: On the basis and manner	of examinati	viedge, death ion and/or inv	occurred at the tivestigation, in my o	me, date and opinion, deat	d place, an	d due to the call at the time, da	use(s) and i	manner as sta e, and due to	ated. the cause(s)
	To the within 2 To the complex.	Ň	29b. Signature and title of certific	Paine	0		29c. Licens	se number	12	29	9d. Date sign	ded (Month, I	Jay, Year)
	140,		30. I me and address of person	who compled cause of	f death (Item	23a) (Tyge,	Print)	101	7/	0 1	11/3	010	
	10		John Wi	MARCA	431	1 MM	lex wo	1/1	11 4	23110	1, 11	1/2	12/8
	Sta Registr		31. Date tiléd (Month, Day, Year	27	strar's Signati		and i			,		,	
Ditt		204		- 1000 Marie		1							

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			1. Decedent's Name (First, Middle, La	st)				2. Date of Death		3. Time of Death		
			Haily Naho	Naho	om Harilu					6 0742 M		
1						4b. City, Town, or			4c. County of Deat	h		
			University of Ma	ryland 191	au Con Conkr	Boltin	nore.		NA			
	Funeral Director				ge (In yrs. last birthday) 13 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes Aug. 17,	9. Birt 1993 Eth	hplace (State or Foreign untry) LOPLA		
	pu ,		Usual Residence of Decedent		10- C't. T							
	anyia •hov	_		h 11						10d. Inside City Limits XXYes 2 □ No		
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Physician Medical Examiner A Estably Name of not insighted a year sing and number of the part of the	Black, White	e, etc.										
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21215	d within piene. r then "	omple			5+) life.	kind of work done on the contract of the contr	furing most of worki }		le			
	othe		17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Maid	len Sumame)			
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Baltii	permit. P Depertm Importar any injui		21. Signature of Fundral Service Licenses 1040 Rockville									
			23a. Part1. Enter the disease, or com	plications that cause	ed the death. Do not ent					Approximate		
	~ :		shock, or heart failure. List only	one cause on each	line.					Interval Between Onset and Death		
п			disease or condition	a Cano	uda se	eptice	mia		Interval Between Onset and Death			
							1	-1 V-1	0 -01	III day		
		- G	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequence of):	reapo	COTONL	CHELLEC	e and	Mrs. 17 Her		
	nsit		Cause (Disease or injury	1 * 0 - 14.00		4. Nu-	0046			FUEDER		
	al-tra	xai	resulting in death) Last		s a consequence of):	41,211,13	1	3		1900 5		
9	sicier buri			4								
289	phy the	D D		. 0.								
Box	he death certi r the attending ched for use a	ysiclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 4☐Pregnant a	2 Fetal death 3					ivery Day Year		
<u> </u>	that i		Part II. Other significant conditions of	ontributing to death	but not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobacc	o use contribute lo	the cause of death?		
ords	requires een sign nould be	ted by	failure to re	spond	to extra			1 🗆 Yes	2 No 3 Pr	obably 4 Unknown		
Rec	The ate h page	Comple	membrane ou	ygenati	ion and	biven	tricular	autopsy performed	? prior to death?	topsy findings available completion of cause of 2 No		
Ħ	stan:	a	25. Was case referred to medical				26. Place of Death	(Check only one)				
<u> </u>	hysic his ca Il dire	0		Pylnpat		II 3 DOA	4 Nursing Ho	me 5 Residence	6 ☐Other (Spec	cify)		
0	ng P			28a. Date of In (Month, D		f 28c. Injun World	at	28d. Describe how in	njury occurred			
<u>0</u>	endi eath. or: A	atl	2 Accident investigation			M 1 🗆	Yes 2 □No					
<u>≅</u>	s after d i Direct d in by	Sertific	dotomicad	28e. Place of Ir	njury - At home, farm, str etc. (Specify)	reet, factory, office				ral Route Number,		
	ne Hoepital n 24 hours he Funarei bletely filled	edical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Example	niner: On the basis	of examination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	29d. I	Date signed (Monti	n, Day, Year)		
,			de mo			Dac	150BL	FS NO	vember	5 2006		
			30. Name and address of person who	completed cause of	death (Item 23a) (Type,					PICAL CENTE		
			John Straumar	IS MD						om NSEIB		
	Sta		31. Date filed (Month, Day, Year)	32. 9 egis	trar's Signature							
: 2	Registr	rar	DEC 0 1 2	2006 /	Se Di Ay	20.462						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2. 0 0

38205

	1- State of Maryland / Department of Health and Certificate of Death	Reg.		,
Physician	1. Decedent's Name (First, Middle, Last) James P. Hightower		Day Year	3. Time of Death
/Medical			27, 2006	3:45 a [™]
Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	tn	4c. County of Death	a
	706 S. Shamrock Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth	Harfor	olace (State or Foreign ntry)
Funeral Director	213-32-3108 1 Nonth Pays Hours Min	Sept. 19	, 1933 Ma	ryland
the Maryland 128-1 show collises at a log collises at the log coll	10a. State 10b. County 10c. City, Town or Location		1	10d. Inside City Limits
Man Man	Md. Harford Bel Air			M∏Yes 2 ☐ No
or 28	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cour	ntry?
death wit	706 S. Shamrock Road 21014		U.S.A.	
teme street	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White,	
5-0036 72 hours after death with the Maryland natural; or Itema 23a or 28a-1 show dical Exact net must be rediffied at etch by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Year or Dates:		Specify: W	hite
ind 21215-0036 be filed within 72 hours att la hygiene d other than "natural", or event, the Musical Exact Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work if the DO NOT use retired)	orking 16t	b. Kind of Business/In	dustry
Ind 2121 be fled within tal Hygiene, d other then event, tre My	12 years insurance claims ad	juster :	insurance	
nd nd nd nd nd nd nd nd nd nd nd nd nd n	17. Father's Name (First, Middle, Last) 18. Mother's Na	me (First, Middle, Mai	den Sumame)	
Vian Ment arkee	W	Laird		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural, or Iteme 23a or 28e-1 show importent: If Item 27 is marked other then "natural, or Iteme 23a or 28e-1 show importent: If Item 27 is marked other then "natural, or Iteme 23a or 28e-1 show once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) Jean L. Hightower/wife 19b. Mailing Address (Street and Number or R 706 S. Shamrock Road			
Baltimore, Miper permit. Pages 1 and 2 Department of Health a Importent: If then 27 is enty injury or other tre	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 200	c. Location - City or To	own, State
Pag Pag ment tury o	`4 □Donation 5 □Other (Specify) Gardens of Faith Cem. 11		altimore,	
Balt Bermit. Depart Import eny inj pnce.	21. Signature of June and Address of Facility Schimunek Funeral	Home of Be	el Air, In	c.
T	23a. P. nt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia			
THE REAL PROPERTY.	shock, or heart failure. List only one cause on each line.			Onset and Death 1
Physician / /Medical	resulting in death)	Cell Lym	4 encor	2 months
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68760, " ifficate be exe 9 physician a as the burial-	d			
9 gg gg gg	IF FEMALE:		1	
Box eath cert attendin for use	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delive Month	ery Day Year
P.O. Box that the death cer ded by the attendir detached for use	1 Yes 2 No 9 Unknown 5 Other (specify) 9 Unknown			
vision of Vital Records, P.O. Box 6876i releating Physicien: The law requires that the death certificate be releath. sctor: After this certificate has been signed by the attending physicis by the funeral director, page 2 should be detached for use as the buffication: To Be Completed by Physiclan/Medical	Part It, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
cords, w requires been sign should be		1 Yes	2 □ No 3 □ Prob	pably 4 DUnknown
i Record The law requir cate has been s page 2 should		24a. Was an	24b. Were auto	psy findings available mpletion of cause of
The lav		autopsy performed 1 ☐ Yes 2 ☑	death?	mpletion of cause of 2□ No
Vital Ficien: The certificate ector, pag		eath (Check only one)	140	
of V hysici his ce il direc	examiner? 1 Yes 2 No	Home 5 Residence	e 6 □Other (Specif	y)
on of Vita ding Physicien: h. Atter this certific funeral director,	27. Manner of Death 28a. Date of Injury 1. Work? 28b. Time of 28c. Injury at 28b. Time of 28c. Injury at 28c. I	28d. Describe how i	njury occurred	
ision ttendii death. ctor: A / the fu	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
- Late 1	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	it and Number or Rura State)	al Route Number,
To the Hospital or within 24 hours at To the Funeral D completely filled in Medical Cell	29a. Certifier (Check hily one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check hily one) 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the caus surred at the time, date	e(s) and manner as st and place, and due to	tated. o the cause(s)
To the within To the comp	29b. Signature and title of certifier		Date signed (Month, Vewber 2	
0/	20. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Mn(n.D.) 602 South Atwood Road # 2	00, Bel:	Air no	21014
State Registrar	31. Date filed (Month, Day, Year) DEC 0 1 2006 See Signature			
DHMH 17 Rev 1/2001	DEC O T SAMP INCOME TO PROPERTY			

DHMH 17 Rev 1/2001

ORIGINAL

		•	1 - For State Registrer	State of Maryland /		rtment of He			ene 0 6	38206
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia /Medic	-	Lorraine.	Jordan				Month	27 200	6 0300 AM
)	Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or L	ocation of Death		4c. County of Dear	
			Johns Hopkins Boyvie	cw Medical Cents	35		nere			N/A
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign puntry)
	Director		211-38-3153	W 200, F 65	Yrs.			Aug. 28,	.1941 _{Ma}	ryland
	and *	1	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Loc	ation				10d. Inside City Limits
	daryl f sho	ō	Marcal					n 2 11		1 ☐ Yes 2🛱 No
	the 28a	Director	Maryland Balt 10e. Street and Number	imore		10f. Zip Code		Dundalk	g. Citizen of What Co	buntry?
	death with the Maryland ms 23a or 28a-f show rmust be notified at		1706½ Woodland D	rive		2-	1222		United S	tates
	death ms 2	Funeral		2. Was Decedent Ever in U.S.	13. W	/as Decedent of His Yes, specify Cuban		ecify Yes or No-	14. Race - Ame	encan Indian,
	or he	필	1 Never Married 2 KMarried	Armed Forces? 1 ☐ Yes 2 ② No				Rican, etc.)	Black, Whit	e, etc.
5-0036	hours after turel', or ite al Examina	p	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		☐Yes 2ÃGNo	Specify:		Specify: W	hite
2	72 h natu	Completed	15. Decedent's Educ (Specify only highest grade		a. Decede	ent's Usual Occupat and of work done du O NOT use retired)	ion iring most of work	ing 1	6b. Kind of Business	/Industry
2	within 72 ene. then "na'	ig m	Elementary/Secondary (0-12)	College (1-4or 5+)						
2	be filed within 72 hours after death with the Marylar at all typiene. Ide thypiene. Ide ther than "naturel", or Items 23s or 28s-f show other than "naturel", or Items 23s or 28s-f show event, the Madical Examiner must be notified at		10 Years 17. Father's Name (First, Middle, Last)		Hous	ewife	IR Mother's Name	e (First, Middle, M.	Own Hom	e
anc	ould be fi Mentai H erked ot etic ever	Be	Henry Crafton Sau	or Cr				ne Sara W		
aryland	should be and Menta a marked umatic ev	2	19a. Informant's Name/Relationship (Typ		h Mailine	Address (Street an			City or Town, State, 2	Zin Code)
Σ	d 2 s th an t7 is i		Mr. James M. Jor						, Marylan	
စ်	1 and Health Iem 27 other tr	1 7	20a. Method of Disposition	20b. Place	of Dispos	ition (Name of	! .		0c. Location - City or	
altimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 is marked any injury or other traumatic a <u>once</u> .		1 Burial 2 □ Cremation 3 □ Re □ Donation 5 □ Other (Specify)	moval from State		atory or other place, Cemetery	12/1/	/2006	Baltimor	e, Maryland
≣	artme ortan injur	li	21. Signature of Funeral Service License			_	1	_		
B	permit. Departrimports any inju		KENTRE S			da-Ruck F 22 Wise F			undalk, I	
Н	_		23a. Part1. Enter the disease, or complic	ations that caused the death. Do						1222 Approximate
	Pnysician		shock, or heart failure. List only one Immediate Cause (Final			Interval Between Onset and Death				
	/Medical		disease or condition resulting in death)	Due to (or as a consequence		ng Canci	cr			1 yr
	Examiner		b							
۳	D =	je	Sequentially list conditions, farry, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequence	a of).					
/	nd	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last					· · · · · · · · · · · · · · · · · · ·		
60	oe execien a		resulting in deathly cast	Due to (or as a consequence	e of):				i	
87	Attending Physician: The law requires that the death certificate be executed robath. •ctor: Atter this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	dicai	d.							
9 ×	sath certific ettending p for use as f	0	IF FEMALE: 23	c. If yes, outcome of pregnancy					and Data of da	
Вох	etten for us	ian	in the past 12 months?	1 Live birth 2 ☐ Fetal dea 4 Pregnant at time of death		Ectopic pregnancy Other (specify)			23d. Date of dei Month	Day Year
o.	that the da led by tha e detached t	Physician/M	1 Yes 2 No 9 Unknown	9□ Unknown	J	Other (specify)				
صِّ	res that igned by be deta	4	Part II. Other significant conditions cont	ributing to death but not resulting	in the un	derlying cause giver	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Vital Records,	puires n sign	d by						1 ☐ Yes	: 2 □ No 3 PI	obably 4 Unknown
<u></u>	w requir s been s should	ete						24a. Was an	24b. Were au	utopsy findings available completion of cause of
æ	The lay	Completed						autopsy	ed? death?	
ta	i cian : Th certificate rector, pag	0	25. Was case referred to medical		•		26 Place of Deat	1 ☐ Yes 21 h (Check only one	_	2 □ No
<u> </u>	ysician: is certific director,	To B	examiner? 1 ☐ Yes 2 No	ospital: Inpatient 2 ER/0	Dutpatient	Other	,		ice 6 ⊟Other (Spe	cifv)
0	g Phys ter this neral di		27. Manner of Death		Time of Injury	28c. Injury : Work?	at	28d. Describe hov		,,
Ö	ath. or: Af	atlc	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(mmay 22) / 32/	,,		es 2 □ No			
Division of	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
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	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medicai	(Check only 2 Medical Examin	icien: To the best of my knowled er: On the basis of examination a	ge, death and/or inv	occurred at the time estigation, in my opi	e, date and place, nion, death occur	and due to the cau red at the time, dat	use(s) and manner as te and place, and due	s stated. e to the cause(s)
	thin 2 the mplel	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License	number	29,	d. Date signed (Mont	h. Day. Yearl
1	7 ¥ 7 8					DEC	000	23	11 / > 0 4 4	
•	İc		30. Name and address of person who cor	notated cause of death (ten 22-	A (Tues 5	Print)	000		11/28/06	
	W	1 9	Cothy Lee	mpleted cause of death (Item 23a 4948 E a s 79 32 Registrar's Signature	ı, (ıypə, r	AVEN.	R.	-	- m1 2	1224
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's Signature		- 1	- 10	INOR	الناري	
	Registr	ar	DEC 0-1-2000	he k	has	100				

ORIGINAL

DHMH 17 Rev 1/2001

06-08973 Robert Judy

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2 Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day November 25, 2006 Judy 0728 hrs **Medical Examiner** Robert 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore County Dundalk 7803 Harold Road 5 Social Security Number Age (In vrs. last birthday) If Under 1 Year | If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Min Months Days Hours Director 212-28-8628 Country) Maryland Aug. 4,1931 1 x M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location any 10a State 1 Yes 2 X No 28a-f show Baltimore Dundalk hours after death with the Maryland Maryland Director l0g. Citizen of What Country s 23a or 28a-f notified at 0 10e Street and Number 10f. Zip Code United States 21222 7803 Harold Road 14. Race - American Indian, Black Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nomust be White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 X Yes 2 White Yes 2 X No specify 3 X Widowed 4 Divorced If Yes, Give Year Specify traumatic event, the Medical Examiner Korean other than "natural". ģ 16a Decedent's Usual Occupation (Give kind of work done 6b Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene 21215-0036 Steel Industry Steelworker 8 Years 17 Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) If item 27 is marked Carrie Hartman William Judy Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21043 2 4710 Ilkley Moor Lane Ellicott City, MD Mr. Robert L. Judy, Jr (Son) Date 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) other Cremation 3 1 X Burial 2 11/29/2006 Middle River, MD Mill Mem. Gdns. rtant; Other Specify ö 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21222 7922 Wise Ave. Dundalk, Maryland Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart l. Enter the disease, or complications that caused the death Approximate Interval **Physician** Between Onset and List only one cause on each line /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED AMENDED sician burial -To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, attending phys for use as the bu 23c If yes, outcome of pregnancy 23d Date of delivery IF FEMALE Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e Did tobacco use contribute to the cause of death? <u>Р</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of has performed? death? ✓ Yes ✓ Yes 2 2 No certificate 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be examiner? Other 7 Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other Scene After this 1 V Yes ٩ 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Manner of Death ✓ Natural Pending Yes 2 No Director: 2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Funeral 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started gal To the one) Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated 29b. Signature and title of 29c License number 29d Date signed (Month, Day, Year) O.C.M.E November 25, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner Jack Titus MD. 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

ENTRICULHA

ue to (or as a consequence of):

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHITAACHEDU

DEC 0

31. Date filed (Month, Day, Year)

MAGANNA.

3 Registrar's Signature

Physician /Medical

Examiner

Immediate Cause (Final disease or condition resulting in death) Examiner

4 Donation 5 Other (Specify)

ature of Funeral Service Licensee

Physician/Medical \$ Completed Be Certification: To ca

burial-transi and physician the as this hours after death To the Hospital or within 24 hours af To the Funeral D

Division or Vital Records, P.O. Box 68760,

or Attending

death.

ATHEROSCLEROTT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? nome 1 ☐ Yes 2 ☐ No 3 Trobably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D0018200 Vadegle Novama

Loudon Park Cemetery 12/1/2006 | Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc.

FIBRILLATION

4107 Wilkens Avenue, Baltimore, Maryland 21229

Approximate Interval Between Onset and Death

11/30/00

TOOL A POOLERD WESTMINSTE?

State Registrar

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 17548 per FH C863 1/24/07 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. N& 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mary E. Kerst November 28, 2006 4:45 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Parkville Morningside House-8800 Old Harford Road **Baltimore** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ar) 1919 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Ye Months 1 □ M 2 □ F September 29, 2006 Virginia 213-18-9616 87 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 01d Harford Road 21234 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Solderer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Veselovsky ပ Barbara Randes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Matterson/Niece 459 Grimaldi Way Hedgesville, West Virginia 25427 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Arlington National Cem. 12/18/06 Arlington Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee Chustina 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4000 OVC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (bicaco of ir jury) that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. ending physician use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? /es 24 No certificate 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this If Director: After this of in by the funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury Natural Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title Certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9512 Harford Hoad Parkith Med 21234 lehammad Kahn ama 31. Date filed (Month, Day, Year) 3. Registrar's Signature State DEC 0 1 Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 6 38210 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear **Physician** RALPH V. KNISLEY NOVEMBER 30 2006 5:05 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Apr. 10,] Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 1922 Maryland 84 Director 213-18-3597 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "netural", or Items 23s or 28s-1 show other traumatic event, the Medical Exampler must be notified at 1√2 Yes 2 □ No Director Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1105 Oakland Terrace Road 21227 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Slatus 1 ∑Yes 2 No 1942 − If Yes, Give Year or Dates: 1946 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Motor Mechanic Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter H. Knisley Carmen R. Reedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Depertment of Health and Important: If Item 27 le n eny Injury or other traun once. Lenore C. Emmerich/Sister 1105 Oakland Terrace Road, Arbutus, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 D'Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 12/5/2006 Crownsville, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses anull 313 Talbott Avenue, Laurel, MD M01103 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or deart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute 044 Physician /Medical Due to (or as a consequence of): 1244 Examiner andiogenic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Physician/Medical Examiner ettending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month 5 Other (specify) P.0. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? ρ Division of Vital Records, mans 1 Yes 2 No 3 Probably 4 Unknown Completed Demento 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٦ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident efter death 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours el To the Funeral D completely filled i 29a. Certifier XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0062213 62 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 SURESH PATEL SHAH ASSOC HOLLYWOOD MD. 20636 . Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 1 2006 Registrar

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KNISLEY

RALPH

■ Baltimore, Maryland 21215-0036

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			State of Maryland / Department of Health and Mo 1 - State Registrar Certificate of Death	ental Hygier Reg. 1	2006 38211
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	Physici /Medio			November 29	, 2006 1:00 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 1332 Halstead Road Park ville	1	4c. County of Death
200	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	Baltimore Co. 9. Birthplace (State or Foreign
ш	Director		-10 00 -021		1931 Maryland
	land w t		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Mary a-f sho fied a	ţo	Maryland Baltimore Co. Parkville		1 □Yes 2√√ No
	or 28%	Direc	10e. Street and Number 10f. Zip Code		Citizen of What Country?
	s 23a s 23a nust b	eral	1332 Halstead Road 21234		United States
21215-0036	be filed within 72 hours after death with the Maryland that Hygliene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ★ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify: Specify Cuban, Mexican, Puerto Forces) 14. Was Decedent of Hispanic Origin? (Specify: Specify:	city Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
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Maryland	12 sho		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural 19b. Mailing Address (Street and Number or Rural 19b. Mailing Address (Street and Number or Rural	Route Number, Cit Itimore,	
	ges 1 and 2 should t of Health and Mer If Item 27 Is marke or other traumatic		20a. Method of Disposition 20b. Place of Disposition (Name of completely com		Location - City or Town, State
Baltimore,	. Ра tmen tant: jury		4 Donation 5 Other (Specify) Moreland Mem. Park 12/01/		ltimore, Maryland
Ba	permit Depar Impor any In once.		21. Signature of European Service Licensee Michael E. Canapp 22. Name and Address of Facility Leonard J. Ruck Inc. 5305 Harrord Road Balt:	imore Maryla	and 21214
٠	100		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	r respiratory arrest,	Approximate Interval Between
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V	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
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	ertifica ding pl		IF FEMALE:		
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
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Records,	e law r has be je 2 sh	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
a F	ician: The certificate ha			performed 1□ Yes 2 X	? death? No 1 ☐ Yes 2 ☐ No
Vital		o Be	25. Was case referred to medical examiner? 1	_	0 Floring (0 - 1/1)
ō	g Physer this eral di	┡─	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28	8d. Describe how in	6 ☐Other (Specify) jury occurred
ion	Attending I r death. ector: After by the funer	atio	2 Accident investigation M 1 Yes 2 No		
Division	tal or Attendi s after death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a place of the date and place, a place of the date and place of the		
	To the within Comp	Me	29b. Signature and title of certifier 29c. License number $D-17041$	29d. [29	Date signed (Month, Day, Year) NOVEM BAR 2006
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ء الاسم	
	Sta	ite	MARC I. LEAVEY MD 1205 York Koad #38 Luth 31. Date filed (Month, Day, Year) 32. Registrar's Signature	CIU(ILL /	11/ 21072
	Registi		MARCI. LEAVEY MD 1205 York Road #38 Luth 31. Date filed (Month, Day, Year) DEC 0 1 2006 March Day (Nonth) Day (Pear) DEC 0 1 2006		

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State of Maryland / Department of Health and Mental Hygiene () () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** PATRICIA ANN LEAHY 11 29 2006 2:10a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE BALTIMORE GILCHRIST HOSPICE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2X F 59 Yrs 212 50 5615 10-06-1947 Director MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE PARKVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA Funeral 8410 NUNLEY DR. APT.C 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: WHITE þ 3 ☐ Widowed 4 ☑ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ST. VINCENT CHILDRENS Elementary/Secondary (0-12) College (1-4or 5+) CENTER ADMINISTRATIVE ASSISTANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 10 HUGH **AMBROSE** CURLEY KATHERINE LAMBERT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CAZENOVIA, NY CHRISTOPHER LEAHY/SON 2318 WELLINGTON DR., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State DULANEY VALLEY 12-02-2006 BALTIMORE, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE. ROSEDALE MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) coun canon Physician Wem mic remons /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 **20**No certificate 1 ☐ Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) WSp(4 1 Yes 2No Hospital: 1 🗍 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 29 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) isterne us ZIZIY 6565 N. Churles St Charles un AMION 31. Date filed (Month, Day, Year) 32. Paistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Dav Year **Physician** ROYCE ALBERT LLOYD November 7:30 24, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3404 Bitterwood Place, Unit Il02 Laurel Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 25, 193 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☐ F 424-36-5959 72 1934 Alabama Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

nt; If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f shov aminer must be notified at 1 ☐ Yes 2☐ No Director Anne Arundel MD Laurel 10g. Citizen of What Country? 10e Street and Number 10f Zip Code 3404 Bitterwood Place 20724 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No 1951 If Yes, Give Year or Dates: −1972 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
Grade 12 College (1-4or 5+) the Analyst National Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Henry Lloyd Laura Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any Injury or other tra once. Mary Alice Lloyd spouse 3404 Bitterwood Place, Unit Il02, Laurel, MD 20724 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State West Arundel Crem. 4 □ Donation 5 □ Other (Specify) 11/28/2006 Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A
313 Talbott Avenue Laurel, M00770 Laurel, Maryland 20707 4 Approximate Interval Between Onset and Death pmplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) **Physician** mall - years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a Was an 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 3□ DOA 2 ER/Outpatient Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061040 2006 Johns Hopking 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 401 N. Bolde R MOPHO MD

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,්ර

Bà Registrar's Signature

06-09014 McKenzie D. Moore

Please Type or Print in Black Indelible Ink

State of Maryland Department of Health and Mental Hygiene	

Kenzie D. Mo	ore	State of Maryland Department of		e 2006 2021
		1- For State Certificate of Registrar		Reg No 2006 3821
Physicia edical Exami		1. Decedent's Name (First, Middle, Last) Mchenzie Demetrice	Moore Nove	ember 26, 2006 1530 hrs
j.		Johns Hopkins Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	le of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ten of Health and Manelal Hygine and Manelal Hygine and Ti starked other than "natural", or items 23a or 28a-f show any nother traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local Baltimo 10e. Street and Number HIB Raynon N A Ve 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) Antonio D Moore 19a Informant's Name/Relationship (Type, Print) 19b Mailing 4113	as Decedent of Hispanic Origin? (Specify Yee's, specify Cuban, Mexican, Puerto Rican, et's Usual Occupation (Give kind of work don lost of working life. DO NOT use retired) 18. Mother's Name (First, Name of Canana and Namber or Rural Roll Roll Roll Roll Roll Roll Roll Ro	10d Inside City Limits 1 Yes 2 No 10g Citizen of What Country? USA sor No- stc.) 14. Race - American Indian, Black, White, etc Specify: Black e 16b. Kind of Business/Industry Middle, Maiden Surname) A White
Physician //Medical Examiner 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator failure. List only one cause on each line. Immediate Cause (Final disease or conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) AMENDED AMENDED AMENDED AMENDED AMENDED 1 23c. If yes, outcome of pregnancy The past 12 months? 1 24 Donation 5 Other Specify 22. Name and Address of Facility Are the past 12 months of the cause of the death. Do not enter the mode of dying, such as cardiac or respirator failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Sequentially list conditions, if any, leading to immediate cause in properties or injury that initiated events resulting in death) Sequentially list conditions, if any, leading to immediate cause in properties or injury that initiated events resulting in death) Due to (or as a consequence of):			tory arrest, shock, or heart Approximate interval Between Onset and Death 23d Date of delivery Month Day Year	
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Division Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Cer	4 Homicide determined (Specify) hOUSE 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence of the basis of examination and/or investigation and manner stated.	rred at the time, date and place, and due to t	imore, MD he cause(s) and manner as started
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			Street, Baltimore, MD 21201	
S Regis	tate trar	116 1 1 1 7/1114 2 16/22 4 A A A	DOME!	

			1 _ State	partment of Health and Mental Hygiene ertificate of Death Reg. No. 2006 38215
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physicia /Medic	_	Thelma lager Maloney	Nov. 28, 2006 8:00 P
)	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
			Gilchrist Hospice Center	Towson Baltimore of If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Experim
	Funeral		5. Social Security Number 6. Sex 1 M 2 N 3 N 4 N 5 N 6 N 6 N 6 N 6 N 6 N 6 N 6 N 6 N 6	y) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 02 08 1925 9. Birthplace (State or Foreign Country)
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	ryland how		10a. State 10b. County 10c. City, Town or	. /
	e Ma Ba-f s	Director	MD Baltimore Towson	
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0	after d or iten niner		Armed Forces?	
<u> </u>	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notifled at	d by	3 ₩idowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No Specify: Specify: White
215-0036	be filed within 72 ho ital Hygiene. id other than "natu event, the Medical	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Girllifa	redent's Usual Occupation 16b. Kind of Business/Industry we kind of work done during most of working DO NOT use retired)
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N Q	filed Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
lan	should be nd Mental marked o	To B	Luther Iager	Ethel Stevenson
Maryland 2	2 sho and is m		19a. Informant's Name/Relationship (Type. Print) 19b. Ma	iling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	s 1 and 3 of Health Item 27 other tra			Alabama Road, Towson, Maryland 21204
Baltimore,			1 Burial 2 Deremation 3 Removal from State	ematory or other place)
ᆵ	it. Pa urtmer urtant: njury			ake Crem. 11.30.06 Beltsville, MD
Ba	permit. Page Department of Important: If any Injury or once.		La Sa Salla Molyuz A	^{22. Name and Address of Facility} Cremation And FuneralBalt. 1ternatives 8717 GreenPastures Dr. MD
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	
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<i>X</i>	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury)	
Ķ	execu າ and al-traı	Examiner	that initiated events resulting in death) Last c Due to (or as a consequence of):	
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Box	leath certific attending p for use as	ian/I	23b. Was decedent pregnant in the past 12 months?	B Ectopic pregnancy Month Day Year
o.	he de the a	Physician/Med	1 □ Yes 2 ⊡No 4 □ Pregnant at time of death 9 □ Unknown	S ☐ Other (specify)
<u>Д</u>	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as I		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
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လ လ	aw requires s been si 2 should b	plete	AVtery disease,	24a. Was an autopsy findings available autopsy prior to completion of cause of
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/ita	Attending Physician: r death. ector: After this certifics by the funeral director, I	Be (25. Was case referred to medical examiner?	26. Place of Death (Check only one)
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Division or	ding Phy h. After thi funeral c	tion:	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	
/ISI	Atten r deat ector: by the	fica	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm,	street, factory, office 28f. Location (Street and Number or Rural Route Number,
á	s after s after at Director	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or Town, State)
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, and due to the cause(s) and manner as stated. investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	thin 24	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
	7 Wil	-	De Signature and the or signature	
,	5		30. Name and address of person who completed cause of death them 23a) (Typ	o D25205 November 29, 2006 e. Print). Charles St. Balto Md 21204
	7			1 N. Charles St. Balto Md 21204
	Sta		31. Date filed (Month, Day, Year) 32. Ligistrar's Signature	loste
	Regist	rar	DEC 0 1 2006 Seem &	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 26 **Physician** 0520 NOVEMBER 200 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST ANDALLSTOWN BALTIMORE HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 F Yrs. Director 78 216-56-7033 Usual Residence of Decedent 09/14/1928 Hungary permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10b. County 10c, City, Town or Location 10d. Inside Çity Limits items 23a or 28a-f show ner must be notified at 1 ✓Yes 2 ☐ No Directo MD Baltimore City Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4800 Yellowwood Ave
11. Marital Status
12. Was Decedent Ever in U.S. Armed Forces? Canada Funeral 21209 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Saltimore, Maryland 21215-0036 þ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Istvan Gregus Gizella Meyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edit Molnar/Friend Important: If Item 2 any injury or other once, 7518 Seven Mile Ln. Pikesville, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov 29 4 □ Donation 5 □ Other (Specify) Parkville, Maryland Moreland Memorial Park 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAL **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit RIGHT FOOT GANGRE Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the' IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown Month Year Day 5 Other (specify) signed by the a Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? /es 2 40 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 219 No 1 ☐ Yes 11 Inpatient ٥ 2 ER/Outpatient 3 DOA nours after death.

neral Director; After this
filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural Injury 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month. Dav. Year) MD D53910 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RANDALISTOWN

State Registrar . MAHESHWARI, MD

2006

31. Date filed (Month, Day, Year)

HOSPITAL GR,

NORTHWOSE

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Motya Malamud 2. Date of Death Day **Physician** Year suambes /Medical 1161611100 The La 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mode 8. Date of Birth (Month, Day, Year) 05/12/1929 (In vrs. last birthdav) **Funeral** Country)
UKRAINE Months Days 1 X M 2□ F 220-47-1431 77 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 □ No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 6920 MARSUE DRIVE APT. 1-B 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married WHITE. 3altimore, Maryland 21215-0036 1 □ Yes 2 No Specify \$ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRINTER PRINTING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be 1 nent of Health and Mental 1 int: If item 27 is marked o ISAAK MALAMUD **ESTHER** ဥ PIROGOVSKAYA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARRA VORONSKAYA / WIFE 6930 BROOKMILL ROAD APT. 1-C - BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other partial ARLINGTON CHIZUK 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □Cremation 4 □Donation 5 □ Other (3 □Removal from State injury or 11/09/2006 BALTIMORE, MD 5 Other (Specify) AMUNO CONG. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Furreral 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last TION APPROVED BY MEDICAL EXAMINER Examiner Acute Cholecystitis as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical CERTIFIC IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 9□Unknown Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 2 No 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ٩ 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 5 Pending investigation 1 Natural Injury 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 2006 State

Registrar

State of Maryland / Department of Health and Mental Hygien@ 1 - For Stata Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2:00 A M ALICE Merson November 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard Howard County General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 2√√ 19, 212-24-3991 79 1927 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2☐No Directo Maryland Howars Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7990 Martown Road 20723 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yes If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XIX No Specify: þ Specify: White 3€XWidowed 4 □ Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grade 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Miles Grace Sealing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8324 Sweet Cherry Lane Laurel, Maryland 20723 Stanley Merson son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State St. Paul's Cemetery 12/01/2006 Fulton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 4 / M00770 313 Talbott Avenue Laurel, Maryland 20707 Approximate Interval Between Onset and Death lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final Chronic Obstructive Pulmoney resulting in death) Due to (or as a consequence of); Papumonia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) -On jestile Heart Due to (or as a consequence of) by Physician/Medical *tF FEMALE* 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ۵ 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOO 63653 November 24, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 Cedar Lane Columbia, MD 21044 Shown Evans 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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Funeral

Director

er then "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at

is marked other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, importent: if Item 27 is marked other any Injury or other traumatic event.

Physician /Medical

Examiner

the attending physicien

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Hospital or Attending Physician:

death.

after death Director:

within 24 hours a To the Funeral L

as the

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detached

page 2 should be

filled in by the funeral director.

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

death with the Maryland

filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

1:00

2006

NOVEMBER 29,

DORIS MULLAUER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Christine L. Myers 10:07 a^M 27, 2006 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Director 80 Oct. 15, 1926 Iowa 483-22-1601 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Md. Harford Bel Air 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21014 U.S.A. 604 E. Squire Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black. White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: white Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) placement counselor state government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred Petty Inez Spengler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 604 E. Squire lane, Bel Air, MD 21014 Theldon Myers/husband 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Bayview Crematory 12/1/06 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee Stel 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Compliere arun disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last corone Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ CVA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an aneu performed? Yes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or within 24 hours after To the Funeral Dire completely filled in L

Medical

29a. Certifier

(Check only one)

31. Date filed (Mon

29b. Signature and title of certifier

DOVIDY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

egistrar's Signatus

State Registrar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

032255

29d. Date signed (Month, Day, Year)

Nevember 27 LUCK

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Physicia edical Examir	n/	Decedent's Name (First, Middle		 gpa1						. Date of Deat Month November	Day	Year	3 Time of Death 0821 hrs
		4a. Facility Name (if not institution				4b. City, To	wn, or Lo	ocation of				inty of Death	
		Laurel Regional Hospi	tal			Laurel					Princ	e George	e's
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs I	ast birthday)	If Under	, -	If Under		8. Date of Birt	h(MM/DD/Y	YYY) 9 Bir Foreig	thplace (State or
Director		129-62-1201	1 M 2 X F	41	Yı	Months s.	Days	Hours	Min.	Sept 2	9, 19		untry) India
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death or the function of the function. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		(or frame)	hysician: To the b	est of my knowled	dge, death occ	curred at the	time, date	e and pla	ce, and c	due to the caus	e(s) and ma	anner as star	rted
To the within To the Comple	Medical	X	and manne	r stated	androi investiç		License		Jan Gu al	o unio, date	,		onth, Day. Year)
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State 31. Date filed (Month, Day, Year)
Registrar DEC 0 1

32 Registrar's Signature

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amend item I per doc, 1/ per fh g864 2-27-07 vt

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jose Amilcar Guerrero Portillo NOVEMBER 29, 2006 03:30FM 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Towson Saint Joseph Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 970 9. Birthplace (State or Foreign 5. Social Security Number 1**X** M 2□ F 212-31-7924 El Salvador Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Maryland Baltimore Baltimore 1 ☐ Yes 2 ☐ No 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21215 El Savadore 77008 Fieldcrest Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc 1 Never Married 2 Married White 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 17. Father's Name (First, Middle, Last) Antonio Alejandro Portillo 18. Mother's Name (First, Middle, Maiden Surname) Maria Elvira Guerrero Aleiandro Portillo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 603 Carroll Ave., Laurel, Md 20702 Marta Guerrero 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Cementerio Eplatanar December 10 1 → Burial 2 □ Cremation 3 □ Removal from State Elplatanar, El Salvador 2006 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Columbia Mortuary Services 306 Park Hall S., Laurel, Md 20724 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): CIRRHOSIS Due to (or as a consequence of) RENAL FAILURE IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy perform 1☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

/Medical Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician: within 24 hours a To the Funeral C To the Hospital

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Items 23a death v

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
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permit. Pages Department of I Important: If its any Injury or o

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Baltimore, Maryland 21215-0036

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Certification:

29a. Certifier

(Check only one)

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Medical 29b. Signature and title of certifier 30. Name and address of person who complete eause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

29c. License number D06002

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

29d. Date signed (Month, Day, Year) 06 0

TOWSON, MARYLAND

OSLER DRIVE 7601 7. Registrar's Signature Of the same

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 10:30A M LYDIA PEARCE 11 26 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE DUNDALK 8167 DELHAVEN RD. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2**X** F 213 20 8076 86 Director 03-22-1920 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 1 XYes 2 □ No NA HIGHLANDTOWN Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 27 N. GLOVER ST. 21224 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: WHITE þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN FLORENCE BLACKBURN SR. ULMONT ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8167 DELHAVEN RD., DUNDALK, MD 21222 MARGARET PARSON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11-29-2006 | BALTIMORE, METRO CREMATORY 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL 21. Signature of Funeral Service Licensee HOME 1211 CHESACO AVE., ROSEDALE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of): Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOME 1 ☐ Yes 2/2010 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Division or Vital Records, P.O. Box 68760

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Simon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scalia

2009

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ORIGINAL

2801

32. Restrar's Signature

29c. License number

24276

29d. Date signed (Month, Day, Year)

11. 27 00

Physician /Medica Examine Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director Baltimore, Maryland 21215-0036

	1 - For State Registrar			viaryiani		Pertificate of			Reg. N	2008		224
an cal	1. Decedent's Name Deboral	n E. Pf						2. Date of D Month Nov.	D.	2006 Year	3. Time of 8:00	
ner	4a. Facility Name (# 4307 K ∈ 5. Social Security No. 215.52	enwood A	Avenue	Age (In yrs. I	las <i>t birthd</i> Yrs	Baltin	If Under 24 Hrs	8. Date of B	irth Day, Year	r) Co	re thplace (State country)	or Foreign
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Funeral Director	10e. Street and Nun 4307 Ke		Venue	nt Ever in U.		10f. Zip Code 21206 13. Was Decedent of If Yes, specify Cu		Specify Yes or N	U.	S . A .	arican Indian,	
by	3 ☐ Widowed	15. Decedent's Ed	Armed Force 1 Yes 2 If Yes, Give Year or Date:	No	16a. De	1 ☐ Yes 2 ☐ No	Specify:			Black, White Specify: Kind of Business.	White	
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To Be	Joseph 19a. Informant's Na	DePaso	-		19b. M	ailing Address (Stree		ia Hog		or Town, State,	Zip Code)	
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	21. Signature of Fu	neral Service Licer	Rette	Moll	143	22. Name and Add	ess of Facility C ives 87	remati 17 Gre	on enP	And Fu	neralB	MD
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cal Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) L	injury	С	as a consequ as a consequ								
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DHMH 17 Rev 1/2001

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760, <

			State of N 1 - State Amend Items 25,27,28	aryland / Depa a-f per ME	artment of H	lealth and N 29/06dhb	lental Hygi	ene 2 0 0 6	30225
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	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	NOVELLOET	4c. County of Death	13:23 P
	LAGIIII	•	Future Care Canton Harbor		Baltimor	<u>~</u>		N/A	
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		place (State or Foreign
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<u>la</u>	uld b Venta rrkad tic e	10	Peter Drymala			Lucy Ol	es		
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Baltimore,	of He litem		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo	sition (Name of natory or other place			0c. Location - City or To	
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of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		104		Check onlone		_
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Sic	Attending r death. ector: After by the fune	cat	2 XAccident investigation 11/13/2			′es 2 X No		d on Food	
Division	or A after Direct in by	Certification:	determined 200. Flace Ul III	jury - At home, farm, stre tc. <i>(Specify)</i>		1	700 Sout	et and Number or Rura State) h Elwood A	Venile
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	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier		29c. License	number	29d	I. Date signed (Month,	Day, Year)
M	⊢≯⊢ŏ		Sm. Zw.		2	i77		,	
		}	30. Name and address of person who completed cause of	loath (Item 22a) (Tues 5		17202		11/13/06	
					•	- 54.		,	
	Sta	te	SATPAL S. DANE M. D. 31. Date filed (Month, Day, Year) NOV 2 9 2006 Section 1	ar's Signature	DIVA AIVE	DAL	IMORE	MD 212	at the
	Registr	ar	NOV 2 9 2006 /	i. Boarle	<i>y</i> -				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23a Pt I per Mt. G62, 12/01/04/05

State of Maryland / Department of Health and Mental Hygiene () () () Amend Items 27,28b,d per McGriffett of Dearthb 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day 25 Physician 1616 PM DeborahA Pierce 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Cowley BALMMORE BALTIMORE CITY RADAMS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign
Country) **Funeral** 1□ M 2XF 46 Yrs 219-82-3273 DEC. 14,1959 MARYLAND Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County d Hygiene. citier then "naturel" or flems 23a or 28a-f ehow vent, the Medical Exeminer must be molified at MARYLAND ANNE ARUNDEL PASADENA 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 UNITED STATES 207 OAK HOLLOW CT. Completed by Funeral Pages 1 end 2 should be filed within 72 hours after death vant of Heelih and Mental Hyglene.
ant: if team 27 le marked other then "naturel", or tleme 23, aur; if then treumatic event, the Medical Experiment must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) **HEALTHCARE** NURSING ASSISTANT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be BARBARA K. CHRISTENBURY WAYNE R. RICH, SR. ٤ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DARREN D. PIERCE / HUSBAND 207 OAK HOLLOW CT., PASADENA, MARYLAND 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition NOVEMBER 29 1 X Burial 2 □ Cremation 3 □ Removal from State Depertment of Important: If eny injury or one. GLEN HAVEN MEM. PARK 2006 GELN BURNIE, MARYLAND 4 Donation 5 Other (Specify) 21. Sign to e on a eral arvice Lice 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY. S.E., GLEN BURNIE, MD 21061 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARPIAC Cessation **Physician** POYEMIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner BRAIN TRAUMATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 TON APPROVED BY MEDICAL EXAMINER Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ been signe should be Coasulorathy 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? CIRRIHOSIS 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Mo OF CIMONIC ALCOHOL ABUSE QUESTON certificete Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only and) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Ulmpatient 2 ER/Outpatient 3 DOA 1 No 2 No ၉ Sign After thi 28c. Injury at Work? 28d Describe how injury occurred Subject fell 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No n 24 hours after death.

• Funerel Director: A sletely filled in by the fi 11/23/06 investigation Unknown[™] 2 Accident 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 207 OAK HOLLOW CT Home 1 45400 W, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 17385 25 2006 ulle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PONMS IEJURIEN RADAMC Conte 32. Registrar's Signature 2006

Registrar

06-09035 Please Type or Print in Black Indelible Ink Gladys Parks State of Maryland / Department of Health and Mental Hygiene 38227 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Month Day November 26, 2006 0950 hrs **Medical Examiner** Gladys M. Parks 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Levindale Hebrew Center Baltimore If Under 1 Year | If Under 24Hrs. 8 Date of Birth(MM/DD/YYYY) 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or **Funeral** Months Days Hours 219-10-2929 Director M 2 X 83 Oct.27,1923 CountryVirginia Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits MD Baltimore Middle River Yes 2 XNo 28a-f show 23a or 28a-f sho notified at once. Director 10f. Zip Code 10e. Street and Number 10g Citizen of What Country? 12609 HArewood Road 21220 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black. or items 2 Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Never Married 2 Married Yes 2X No White Yes 2 X No specify. 3 Widowed Divorced Yes, Give Year Specify Examiner ş 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) d Mental Hygiene s marked other than "n ife event, the Medical E should be filed within 72 h and Mental Hygiene Homemaker Baltimore, MD 21215-0036 own home 6th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry C. Reed Toye B. Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is m MAry Wilson / daughter 2165 HAven Oak Court Abingdon MD 21009 ses i mi it of Health a it: If item 2' Pages 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Artment or apportant: H XBurial 2 Cremation 3 Removal from State Gardens of Faith 11/30/06 Rossville Md Donation 5 Other Specify 21. Signature of Funeral Service Licen 22. Name and Address of Facility 300 Mace Avenue Balto. Connelly Funeral Home of Essex 21221 eations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock Approximate Interval Physician /Medical 23a Part I. Enter the disease, or compl failure List only one cause on each line Between Onset and Death Multiple injuries with complications Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical X UNPENDED AMENDED #23a,27,28a-f 2863, 1/24/07 TT perME. Box 68760 IF FEMALE: 23d. Date of delivery phy 23c. If yes, outcome of pregnancy 23b Was decedent pregnant in the Live birth Ectopic pregnancy Year Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 V No Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ examiner? Hospital: 1 / Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 Other DOA 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. the Funeral Director: After pletely filled in by the funera 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury Medical Certification: subject was a passenger in auto to Natural Yes 2 X No Pending 12/11/2004 4:03 pm auto collision 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Location (Street and Number of Rural Route Number, City or Town, State) Fastern Blvd. @ Farls Rd. 3 Could not be Suicide determined (Specify) 4 street Homicide Middle River. MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) To the o the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Aff certif 29d Date signed (Month, Day Year) Sapatura 29c. License number OCME November 28, 2006 Mome and address of person who o impleted cause of death (Item 23a) (1) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD.

DHMH 17 Rev 1/2001 OCMF 2006

State Registrar 31. Date filed (Month, Day, Year)

2006

		-	For State Registrar	State of M	laryland		artment				ental Hy	giene Reg. No.	. 0 0 0	382	28
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	Examin	er	4a. Facility Name (If not institution, south 5 Hopkins Bay	view Care	Cent		Bal	timo	Location o				County of Deat		
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	aryland show		Usual Residence of Decedent 10a. State 10b. County			Town or Lo								10d. Inside C	ity Limits
	the Mark	recto	MAryland Balti 10e. Street and Number	more	W	hite	Marsh 10f. Zip					10g. Citi	zen of What Co		2Д/10
	th with	al Di	11345 Pulaski Hi	ghway Lot	13			211	62				USA		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "nature!, or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☑ Divorced	12. Was Deceden Armed Forces d 1 Tyes 2X If Yes, Give Year or Dates	?]No		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexican Specify:		ify Yes or No ican, etc.)	0-	14. Race - Ame Black, White Specify: Wh	e, etc.	
215-0036	within 72 hou ene. than "natura he Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)	5+)	16a. Deced (Give life. I	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired)	ition uring mosi	t of working	9	16b. Ki	nd of Business/		
7	tygien Har th har th	Con	9 years 17. Father's Name (First, Middle, La	act)		Wire	Mill			ar's Name	First, Middle		thlehem	Steel	
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Mary	id 2 sho Ith and I Z7 is ma traums		19a. Informant's Name/Relationship Lisa McLaughlin	_(Турв, Print) Daught	er		•	•					7 Town, State, 2 21222	ip Code)	
Jre,	of Health itam 27 i	ľ	20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Narr	ne of		vovem)			cation - City or	Town, State	
altimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		1 ☐ Burial 2 【** Cremation 3 ** 4 ☐ Donation 5 ☐ Other (Spe	ecify)	Bay	view		_	i	30,20	006		imore C).
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	/Medical Examiner			- ;	s a conseque	ance of): 16 use								Yeus	
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	w requires that the death s been signed by the atter should be detached for u		Part II. Other significant condition Asbes tosis, Hy	s contributing to death		ing in the u	1 .	-					se contribute to		leath? Jnknown
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Divisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be	njury - At hom etc. <i>(Specify)</i>	ne, farm, str	eet, factory				of. Location (City or To	Street an wn, State	d Number or Ru)	rai Route Num	ber,
	na Hospiti n 24 hours na Funara sletely fille	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the bes xaminer: On the basis and manner s	of examination	n and/or inv	vestigation	in my on	inion deat	th occurrer	at the time	date and	place and due	to the cause/s	()
	To th within To th	Me	29b. Signature and title of certifier	(Z	nes	>	29c	License	number	23		29d. Dat	e signed (Month Ember- nd 212	Day, Year)	06
	20	j.	30. Name and address of person & William Greenough	no completed cause of	death (Item 2	Bayvie	Print)	de	Balt	imor.	e Ma	ry la.	nd 212	24	
G.	Sta Regist		31. Date filed (Month, Day, Year)	2006 32.49919	trar's Signati	* A									

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physicien and the burial-transit Division of Vital Records, P.O. Box 68760, attending pl certificate has been signed by the rector, page 2 should be detached funeral director. this After

RAESLER

SHIRLEY

NOVEMBER

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:20 P M Raesler November 30 2006 Shirley Delores /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Stella Maris Hospice Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F Yrs. Director 1936 Maryland \$ept. 213-32-3247 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f ehow in then "naturel", or itame 23a or 28a-f eho 1 ☐Yes 2 ☐ No Director NA Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 U.S.A. death 1111 Bonsal Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify Specify: þ White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Crown, Cork and Seal Assembly Line 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be find and Mental H Laird Evelyn Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Depertment of Health ar
Important: If item 27 is
eny injury or other trau 1453 Andre Street Baltimore, Maryland 21230 Shirell Wright (Daughter) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) December Bayview Crematory Inc. 2,2006 Baltimore, Maryland 21. Signature of Juneral Service 22. Name and Address of Fac me and Address of Facility
Dabrowski/Chojnacki Funeral Homes P.A. ask 1005 Dundalk Ave. Baltimore, Maryland 21224 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ong cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading 10 in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🛣 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Medical Certification: To 1 ☐ Yes 2 😿 No 3 DOA HOSPICE 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident Injury s after dec-ai Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funaral D completely filled in TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one the 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. DR. TARIQ MAHMOOD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Randy Lee Rakes

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Physicia		Decedent's Name (First, Midd						_		2.	Date of Deat Month	h Day Yea		3. Time of Death	
edical Examin						RAKES					November	29, 2006		0037 hrs	
		4a Facility Name (if not institution		and number)			Town, or Lo tminster	ocation of [Death		4c. County of Carroll	of Death		
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Funeral		5. Social Security Number	6. Sex			ast birthday)	If Und Month	ler 1 Year	If Under 2 Hours	Min.		h(MM/DD/YYYY	-		ANID
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5-0036 led within 72 fygiene other than the Medical	Ē	17. Father's Name (First, Middle	Last)			CAF	RPENT	rer Lie	Mother's	Name (F	irst Middle M	Maiden Surname)		
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica		17. Patrier's Name (First, Middle		IAM I	LEONA	ARD RA	KES,			ANE		IGELS			
21215-0036 uld be filed within 7. Mental Hygiene marked other than	e Be	19a. Informant's Name/Relation				- Company (1)		C		_		ber, City or Tow	n, State,	Zip Code)	
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland thth and Mental Hygiene m 27 is marked other than "natural", or items 23a or 28a-f she aumatic event, the Medical Examiner must be notified at once	-	JEANE E. BL			THER	2193	BAI	TIMO	DRE I	BLVI)., F	INKSBUF	≀G,	MD 210	48
and 2 lealth tem 2	ŀ	20a. Method of Disposition			20b. F	Place of Dispo			etery	I	Date	20c. Location -	City or T	rown, State	\neg
more, MD 2121 Pages 1 and 2 should be fi eent of Health and Mental 1 int: If item 27 is marked r other traumatic event.		1 Burial 2 Crematic	n 3 Ren	noval from S	tate	crematory or o	ther place) אידיני (:) האואיםי	resv.	12	/2/06	NEW WI	NDS	OR	
timent trans	-	4 Donation 5 Other S			БТЕ									OME, P	7
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Med		21. Funeral Service	Licensee											ID 2115	
	-	23a. Part I Enter the disease, o	r complication	s that cause	d the death.	. Do not enter	the mode	of dying, si	uch as car	diac or n	espiratory arr	est, shock, or he	art	Approximate Int	
Physician /Medical		failure List only one cause	e on each line.											Between Onse Death	et and
Examiner		Immediate Cause (Final diseas or condition resulting in death)		ole Injurie (or as a con		f)·	_								
)		One of the list and disease	b.	(0. 00 0 00.		.,.									
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nsi A ed	Exa	events resulting in death) Last	d d	(or as a con	sequence o	··).									
760, cate be executed physician and the burial - transit	ह	UNPENDED		NDED								-			\neg
e be e	/Medical			If yes, outco	omo of prog	IDODOV	_					23d Date of	delivery		
Box 68760, edeath certificate be the attending physicized for use as the burited for use as the burited for the same and the burited for the same as the burited for the same as the burited for the same as the burited for the same same same same same same same sam		IF FEMALE: 23b. Was decedent pregnant in	Alexan Com	Live birth			etal death	3	 Ectopic p	regnand	у	Month	Da	ay Year	ar
30x 68 death certi he attendin d for use a	icia	past 12 months?	4	Pregnant a	at time of de	oth _	Other (Spe								
O. Box 687 at the death certific d by the attending p	Physicia		nknown 9	Unknown			_								
P.O. res that the signed by be detach		Part II. Other significant cond	itions contrib	outing to dea	ath but not r	esulting in the	underlyin	g cause giv	en in Part	l.				he cause of death	
signe signe	d by													ably 4 Unkn	
ords, v requires should	ete										24a Was autop	sy p	orior to co	opsy findings ava ompletion of caus	se of
Reco The law icate has	Completed										perfo		death?	s 2 N	No
tal Reco cian: The law certificate has		25. Was case referred to medic	al					26.Place of	of Death (C	heck on	-		r. J		
Division of Vital Records, rate or Attending Physician: The law requir rs after death at Director: After this certificate has been seled in by the funeral director, page 2 should	o Be	examiner? 1 ✓ Yes 2 No	Hospital	1 Inpat	ient 2 🗸	ER/Outpatie	nt 3 I	DOA C	other 1	Nursing	Home 5	Residence 6	Other:		
n of V ling Phy After th funeral o	_	27 Manner of Death	28	a. Date of In (Month, Day Iov 28, 200	jury	28b. Time o	f Injury	28c. Injury	at Work?	2	8d. Describe	how injury occurr	ed		
anding th r: Af	ţion		lullig	lov 28, 200	6 (Fear)	2359 hrs		1 Y	es 2 🗸 N	10 P	edestrian	struck by ver	licle op	perated by po	olice
iSic	ica		estigation 28	Be. Place of	Injury - At h	I iome, farm, sti	eet, factor	y, office bu	ilding, etc.	2			er or Rur	al Route Number	r, City
Division pital or Attencours after death eral Director:	Certification:	Juicide	uld not be	Specify) M	ajor Roa	d / Highwa	ay			R	or Town, S oute 140 ne	^{State)} ar Sandymoun	t Road,	, MD	
Division Hospital or Attened 24 hours after death Funeral Director:		29a. Certifier	Physician: To	the best of	my knowled	ige, death occ	urred at th	ne time, dat	e and plac	e, and d	ue to the caus	se(s) and manner	as starte	ed.	
Division of Vital Records, P.O. In to the Hospital or Attending Physician: The law requires that the within 24 hours after death To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be deached.	Medical	(Check only centifying one) 2 Medical Ex	aminer: On the	e basis of ex	amination a	and/or investig	ation, in m	ny opinion,	death occu	irred at 1	the time, date	and place, and o	lue to the	cause(s)	
To wit To	Mec	29b. Signature and title of certi	_	nanner state	u	-	29	c License	number		-	29d. Date sign	ed (Mon	th, Day, Year)	\dashv
/		A Colo San the	1 000					O.C.N	1.E.			November	29, 20	06	
		30. Name and address of person	on who comple	ted cause of	death (Item	n 23a)									
')		Pamela E. Southall,		istant Me			11 Peni	n Street,	Baltimo	re, Mi	21201				
	tate			_	rar's Signat		- 1-		_						$\overline{}$
Regis			2006	Mich	wh	× An	ufe								

			For State Registrar	State	of Mary			ment of He		and Me		giene Reg. No.	(U U ()		38231
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)		7.7	- 1 to 20	Droi	piennik			2. Date of De Month			r	3. Time of Death
	/Medic	al	As Callin Name //	Samue	2 T	alter		c. City, Town, or I	L sestion o		Novemb		8, 200	10	10:45 R M
	Examin	er	4a. Fecility Name (If not institution, give Eastpoint Rehab. 8			ome	46		tpoi			40.			e Co.
	Funeral		5. Social Security Number 6. Sec	(n yrs. last birth		Under 1 Year	If Under	24 Hrs.	8. Date of Bir	th V Year)	0.5		ice (State or Foreign
	Director		217-22 0000]M 2□F	77	Y	rs. M	onths Days	Hours	Min.	Month, Da	3,19	28	Jounti	Marvland
	and **	1	Usual Residence of Decedent 10a. State 10b. County		10	Oc. City, Town	or Locati	on						10	d. Inside City Limits
	Maryl	Į.	Maryland Harfo	ord					Bel	Air					1 ☐ Yes 2 🛣 No
	r 28e	Director	10e. Street and Number					10f. Zip Code				10g. Citi	zen of What	Count	ry?
	th wit		14 Bonnie Avenue	1					21	014		Un	ited S	tat	ies
	teme teme	Funerai	11. Marital Status	12. Was Dec Armed F	orces?	r in U.S.	13. Was	Decedent of His es, specify Cuban	spanic Ori	gin? (Spec n, Puerto F	cify Yes or No Rican, etc.)	-	14. Race - Ar Black, Wi		
50	rs after	by F	1 ☐ Never Married 2 ☐ Married ☐ 3 ☑ Widowed 4 ☐ Divorced	1 K∆Yes If Yes, G Year or [2 ☐ No ive Dates:		1 🗆	Yes 2⊠ No	Specify:				Specify:	Whi	ite
ž	filed within 72 hours after death with the Maryland Hygiene. wher then "nature!", or tteme 23a or 28e-f ehow ent, the Maolical Exactinate out by nutified at	ted	15. Decedent's Edu	cation		16a. [Decedent	's Usual Occupa	tion	a m f m al esan		16b. Ki	nd of Busines	s/Indu	ıstry
7	thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)		1-4or 5+)			d of work done do NOT use retired)	uring mosi	t or workin	9	~1		7	
2	led will her the her the	Co	12 Years			1	Mach	inist	10 14-15-	ede Nome	/Fine & Adiabate		ip Yar	d	
Maryland 21215-0036	B is b	Be	17. Father's Name (First, Middle, Last) Simon Rzepiennik						18. MOTHE	er s marne	(First, Middle, Kather				
2	should ind Men marke umatic	ဥ	19a. Informant's Name/Relationship (Ty	pe, Print)		19b.	Mailing A	ddress (Street as	nd Numbe	er or Rural	Route Numb	er, City o	r Town, State	, Zip C	Code)
	1 and 2 Health a tem 27 le		Mr. David Rzepier	nnik	(Son)	14	4 Boı	nnie Ave	e. B	el Ai	r, Mar	ylan	d 210	14	
e,	S 0		20a. Method of Disposition 1X Burial 2 Cremation 3 F	lamoval from	9670	20b. Place of I	Disposition, cremato	on (Name of ory or other place)	Da	ate	20c. Lo	cation - City	or Tow	n, State
Ĕ	Pages ment of lant: If It		4 Doration 5 Other (Specify)			St. St	tani	slaus Ce	em.	12/2	2/2006	Ва	ltimor	e,	Maryland
Baltimore,	permit. Pag Depertment Important: I eny Injury o		21. Sign ture of Aurieral Se vice bioens	Fr	Vh			ame and Address da-Ruck 22 Wise			Home of	Dun Mary	dalk, land	Ing 212	222
			23a. Part. Enter the disease, or compleshock, or heart failure. List only of	ications that ne cause on	caused the each line.	e death. Do no	ot enter th	ne mode of dying	, such as	cardiac or	respiratory a	rrest,		1	Approximate nterval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a		DOER		4WCER						,	Onset and Death
	/Medical Examiner		Tooling in docum	Due to	(or as a co	onsequence of	f):	•							
	III III	er	Sequentially list conditions, tany, leading to introduct cause. Enter Underlying Cause (Disease or injury	Due to	(or as a o	onsequence of	f):							-	
	cuted nd ransit	Examiner	triat initiated events	s											
Ď,	ate be executed hysicien and the burial-transit	Ex	resulting in death) Last	Due to	(or as a co	onsequence of	f):								
9/8	icate be executed physicien and s the burial-transit	dlcai		d		_								-	
0 X	The law requires that the death certific vie has been signed by the ettending p bage 2 should be detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, ou				7507					23d. Date of c	leliven	,
Box	death e etter	iciar	in the past 12 months?	4□Preg	nant at tim	Fetal death e of death		topic pregnancy her <i>(specify)</i>					Month		oay Year
0	res thet the de signed by the e I be detached f	hys	9 Unknown	9□ Unkr											
_	es the igned be de	þ	Part II. Other significant conditions co	ntributing to	ieath but n	ot resulting in	the unde	rlying cause give	n in Part I.						cause of death?
ord	w require been si should l	eted									10	Yes 2[Probal	
Division of Vital Records,	has b	Completed									24a. Was autop		24b. Were prior to death	o com	sy findings available pletion of cause of
g		e Co	25. Was case referred to medical						00 Di	-1015	1 ☐ Yes	2 € No	1 🗆 Y	es 2	!□ No
5	ysicie is certi directo	To Be	examiner?	lospital:	Inpatient	2 ☐ ER/Out	patient	3□ DOA Othe			(Check only only only only only only only only		S □Other /Sr	necify)	
<u></u>	Attending Physicien: The rideath. c death. sctor: After this certificete hiby the funeral director, page		27. Manner of Death Natural 5 ☐ Pending	28a. Date		28b. Ti		28c. Injury Work			8d. Describe			,,	
<u> </u>	Vttendir death. ctor: Af y the ful	atlo	2 ☐ Accident investigation						′es 2 🔲	No					
$\frac{3}{2}$	l or Atten after deat Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		e of Injury ling, etc. (S	- At home, fare Specify)	m, street,	factory, office		2	81. Location (City or To	Street and vn, State	d Number or .)	Rural	Route Number,
	Hospital 14 hours a Funerel C		29a. Certifier 1 Certifying Phy	sician: To th	e hest of m	ny knowledge	death or	curred at the time	e date an	d place a	nd due to the	cause(s)	and manner	ac eta	tod
	I 4 II 6	edicai	(Chack only one)	nar: On the I	pasis of ex nner stated	amination and	Vor invest	igation, in my opi	inion, dea	th occurre	d at the time,	date and	place, and d	us stat	he cause(s)
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier	-1				29c. License	number			29d. Dat	e signed (Mo	nth, D	ay, Year)
			Malay Weller		, M	1		D0060	1560)		NOW	EMBER	1 2	r, 2006
	5+1		30. Name and address of person who	mpleted cau	se of deat	h (Item 23a) (T	Type, Prir	nt)		2.4		0.		٠.	4.1
ŕ			31. Date filed (Month, Day, Year)	32	ZUJ, Redstrar's	Signature	KVI	SIL IVE	ac f	SA .	109	DA	LIMU	LE	ey, Year) K, 2006 Mb
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38232 Certificate of Death 2. Date of Death Month November 26 2006 4b. City, Town, or Location of Death 4c. County of Death Towson If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Baltimore 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Months 1 □ M 2 □ F 88 June 10 1918 Norwich, NY 10c. City, Town or Location 10b. County Baltimore Baltimore County 10f. Zip Code 10g. Citizen of What Country?

1. Decedent's Name (First, Middle, Last) **Physician** Salvatore Thomas Ruffo 3:12 am /Medical 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center Social Security Number Birthplace (State or Foreign Country) **Funeral** 128 10 8476 Director Usual Residence of Decedent the Maryland 10a. State 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No **Funeral Director** Maryland 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or; any injury or other traumatic event, the Medical Examiner must be none. 1830 Hanford Road 21237 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 MYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify Specify: þ 3 ₩ Widowed 4 Divorced White W II Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Quality Control Inspector Baltimore County Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pasquale Ruffo Isabelle Friejio ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kenneth Ruffo (Son) 4 Overshot Court Phoenix, Maryland 21131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Gardens of Faith Cem. November 29 2006 |Baltimore,Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lenows /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examine physician and is the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending properties 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy oerforn Be (25. Was case referred to medical examiner? 26. Place of Death (Check only og Other: 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) HOSPICE Certification: To 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Natural
Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 1891 . Chailes Street/Balto MD 21204 N 6601 rev (knesmb Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department of Health and Mental Hygiene 10 10 2022
		4	For State of Maryland / Department of Health and Mental Hygiene 1 State Certificate of Death Reg. No. 38233
	* *		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
П	Physicia /Medic		Julius Kohrbach November 28 2006 1:30 Am
	Examin	4. 6	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
			St. Elizabeth Nursing Center Baltimore NA
6.	Funeral		5. Social Security Number 6. Sex 1. Age (in yrs. last birthday) If Under 1 Year II Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Mnn. (Month, Day, Year) 9. Birthplace (State or Foreign Country) 1. Age (in yrs. last birthday) 1. Age (i
	Director	-	217 14 2120 14 21 84 Yrs. 01-19-1922 MD
	yland		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	e Mar	ctor	MD BALTIMORE ROSEDALE 1 □ Yes 2√2 No
	ith th	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	s 23a	rai	2019 KELBOURNE RD. APT. 201 21237 USA 11 Martial Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
	item item	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 \(\triangle \triang
38	urs af		If Yes, Give 1 □ Yes 2 X No Specify: Specify: WHITE
Ö	filed within 72 hours after death with the Maryland Hygiene. Ather than "neturel", or items 23a or 28a-f ehow ent, Ite Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry
2	ithin 7	npie	Elementary/Secondary (0-12) College (1-4or 5+)
21	led w lygier her th		11 0 PROD. CLERK STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
and	ntal H od ot	Be	
Ž	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If Item 27 is marked other than "neturel", or items 23a or 28a-f ehow or other traumatic event, the Medical Examinatings in collised at	2	JULIUS ROHRBACH SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ma	and 2 sealth ar n 27 is		JEAN ROHRBACH/WIFE 2019 KELBOURNE RD. APT 201 ROSEDALE, MD 21237
ē,	s 1 ar f Hea f Hea othe		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
E	Pages nent of int: if it		1 Description 3 Removal from State GARDENS OF FAITH 11–30–2006 BALTIMORE, MD
Baltimore, Maryland 21215-0036	permit. Pages Department of Himportant: If Ite any injury or of page.	ı	21. Signature of uneral Service Licensed 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME
	89 2 2 9		1211 CHESACO AVE., ROSEDALE, MD 21237
п			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Approximate interval Between Onset and Death
100	Pnysician	4	disease or condition disease or condition a Or on any art of the years
1	/Medical Examiner		Due to for as a consequence of):
		ا ا	Sequentially list conditions D.
V.	uted d ansit	Examiner	The desired training to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. Due to (or as a consequence of): Winth Minth C.
oʻ.	be executed ician and burial-transit		Due to (or as a consequence of):
3760,	9 × 9	icai	la History of bladder cancer years
68 ×	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Medi	IF FEMALE:
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1
	he de the a	ysic	1 Yes 2 No 9 Unknown 9
P.O.	that the by detail	y Ph	Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ds	quires n sign	d by	Peripheral vascular distaste 10 yes 20 No 30 Probably 4 Munknown
000	sw requir s been s	Completed	24a. Was an autopsy findings available
Re	The lav	E O	autopsy performed? CNVONIC VENAL INSUMICIENCY autopsy performed? death? 1 Yes 2 No 1 Yes 2 No
ital		Bec	25. Was case referred to medical asymmetr?
<u>></u>	hysic his ce Il dire	0	1 ☐ Yes 2 No
Division of Vital Records,	Attending Physician: r death. sctor: After this certific by the funeral director,	0	27. Magner of Death 1 Z Natural 5 Pending (Month, Day Year) Natural 5 Pending investigation 28a. Date of Injury 28b. Time of Injury 28d. Injury at Work? 28d. Describe how injury occurred 28d. Desc
isio	death death ctor: / the f	icat	3 Suicide 6 Could not be 28. Blood of Injury At home form stoot feeton office.
ĕ	after Dire	Certification:	4 Homicide determined determined building, etc. (Specify)
	Hospital or 4 hours afte Funeral Dire tely filled in t		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within 2 To the comple	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ming Vi MD 3320 Benson Avenue, Baltimore, Maryland 21227 31. Date (Item 1) Day, Year) 32. Registrar's Signature
	THI		30. Name and address of person who completed dayse of death (Item 23a) (Type, Print)
1	Sta	ite	31. Date file (Month, Day, Year) 32 degistrar's Signature
	Registi		DEC 0 1 2006 Some & specie

Jay Ashley Randolph

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2006 3823	2	00	6	3	8	2	3	
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		- For State Certificate of Registrar	Death	_ R	eg No. 2000 3023
Physician Medical Examine	1	1 Decedent's Name (First, Middle,Last) Jay Ashley Randolph		2. Date of Dea Month Novembe	th Jay Year 727, 2006 3. Time of Death 1545 hrs
	4	4a. Facility Name (if not institution, give street and number) 428 Concerto Lane	b. City, Town, or Location of Death Silver Spring	n	4c. County of Death Montgomery
Funeral Director	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	If Under 1 Year If Under 24Hr. Months Days Hours Mir		th(MM/DD/YYYY) 9 Birthplace (State or Foreign Country/Germany
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits
yland -f show once.	<u> </u>	Maryland Montgomery 10e Street and Number	Silver Spring 10f Zip Code	I 1	1 Yes 2 X No
ith the Maryland 23a or 28a-f show any notified at once.		628 Concerto Lane	20901		United States
eath w	rullera	1 X Never Married 2 Married Armed Forces? If Yes 1 Yes 2 X No	s Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puerto Yes 2 X No specify:		14 Race - American Indian, Black, White, etc. Specify: White
atural",		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	's Usual Occupation (Give kind of est of working life DO NOT use rel		16b. Kind of Business/Industry
15-0036 filed within 72 hours after d d other than "natural", or t, the Medical Examiner in	nalaidillo	Elementary/Secondary (0-12) College (1-4 or 5+) 5+ (Un:	employed)	,	N/A
	2	17. Father's Name (First, Middle, Last) William Ferral Randolph	Inga I	Elser	Maiden Surname)
MD 2. ad 2 should alth and M m 27 is m: aumatice	2	John Ashton Randolph / Brother 628	Concerto Lane,	Silver S	
o	- 1	1 Burial 2 X Cremation 3 Removal from State Chesapeak	tion (Name of cemetery, er place) e Crematory 1	Date 1/30/06	20c. Location - City or Town, State Beltsville, MD
Baltimore, permit Pages I an Department of Her Important: If ite injury or other tr	1	4 Donation 5 Other Specify 21. Signifique of Foreign Services Licensee Moo 3 8 Z 9 3	are are Address a Tackynd (3 Gist Ave., Si	Crematio lver Spr	on Services ring, MD 20910
Physician /Medical	1	23a. Part I Enter the disease, or complications that caused the death. Do not enter th failure. List only one cause on each line	e mode of dying, such as cardiac	or respiratory arr	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a Cirrhosis of the Liver Due to (or as a consequence of):			Death
	ie	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
ed with A	티	(Disease of many that historic events resulting in death) Last Due to (or as a consequence of): d.			
0, e be executed vsician and burial - transit	n/Medical	UNPENDED AMENDED			
Ox 6876 eath certificat attending phr for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fet 4 Pregnant at time of death 5 Oth 9 Unknown	al death 3 Ectopic pregner (Specify)	ancy	23d Date of delivery Month Day Year
that the done of detached i	yo P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I		obacco use contribute to the cause of death? s 2 ✓ No 3 Probably 4 Unknown
rds, F v requires s been sig should be	Completed			24a. Was	an 24b. Were autopsy findings available
tal Reco	E			1 🗸 Yes	ormed? death? 2 No 1 Yes 2 No
Vital Rec	o Re	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26 Place of Death (Check 3 DOA Other Nurs	ing Home 5	Residence 6 🗸 Other: Scene
Division of Vital Records, P.O. all or Attending Physician: The law requires that us a after death The This certificate has been signed beled in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	- 1	27. Manner of Death 1 V Natural 5 Pending 28a Date of Injury (Month, Day, Year) 28b Time of Ir	njury 28c. Injury at Work?	28d Describe	how injury occurred
Divisior ital or Attendurs after death ral Director: lled in by the iter.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street (Specify)	et, factory, office building, etc.	28f, Location (or Town, \$	Street and Number or Rural Route Number, City State)
Di To the Hospital within 24 hours a To the Funeral completely filled	Medical C	29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated	red at the time, date and place, an ion, in my opinion, death occurred	d due to the cau at the time, date	se(s) and manner as started and place, and due to the cause(s)
F » F »	Me	29b Signature and title of certifier	29c License number O.C.M.E.		29d Date signed (Month, Day, Year) November 28, 2006
10		30 Name and address of person who complet and as se of death litem 23a) Susan Hogan MD. Assistant Medical Examiner 111 Pen	n Street, Baltimore, MD 2	1201	
Sta Registr		31 Date filed (Month, Day, Year) 32 Egistrar's Signature	d)		
DHMH 17 Rev 1/200		ORIGINA	L		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 005 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 23, 2006 3:15 A Elinore Rose

/Medic	an ai	Miriam	Elinore	Rose		November	23, 2006 3:15 A
Examin	_	4a. Facility Name (If not institut			4b. City, Town, or Location of Dea	ath 40	c. County of Death
		Potomac Valley	Nursing Cente	r	Rockville		Montgomery
Funeral Director	== =	5. Social Security Number 028-16-0549		(In yrs. last birthday) 84 Yrs.	If Under 1 Year		9. Birthplace (State or Foreign Country) New York
Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. Coun Maryland Mon	tgomery	IOc. City, Town or Le	Rockville		10d. Inside City Limit
n with the 3a or 28a at be notif	al Director	10e. Street and Number 1235 Potomac	Valley Rd.		10f. Zip Code 20850		itizen of What Country?
I within 72 hours after death with the Maryland liene. Item "natural", or items 23a or 28a-f ehow the Maryleal Examination notified at the Maryleal Examination notified at the Maryleal Examination notified at the Marylea	by Funeral	11. Marital Status 1 Never Married 2 M 3 Widowed 4 MODivorce	If Yes Give		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes XX No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
nin 72 ho in "natur Modical	Completed	15. Deced (Specify only high Elementary/Secondary (0-12	ent's Education hest grade completed)) College (1-4or 5+)	(Give	edent's Usual Occupation a kind of work done during most of w DO NOT use retired)	orking 16b. I	Kind of Business/Industry
It hyg		Unknown 17. Father's Name (First, Middle	Unknown		Astrologist 18. Mothers N	ame (First, Middle, Maide	Science
should be and Mental marked o umatic eve	To Be	Joseph 19a. Informant's Name/Relatio		Cohen	Sad		cht
1 4 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			/ Conservator	1725	ing Address (Street and Number or I K St. NW, #1202	; Washington	D.C. 20006
S to H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	n 3 Removal from State		osition (Name of matory or other place)		ocation - City or Town, State
permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service		00382 R	2. Name and Address of Facility, app Funeral and	Cremation Se	rvices
		23a Part 1 Enter the disease	or complications that caused the		33 Gist Ave., Si		Approximate
hysician		Immediate Cause (Final	ist only one cause on each line.	\circ	iter the mode of dying, such as cardi	ac of respiratory arrest,	finterval Between Onset and Death
/Medical Examiner		disease or condition resulting in death)	Due to (or as a	consequence of):			Imes
e executed sian and urial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 c	consequence of):	abstructure 1	ung dis	rease years
mat me death certificate Led by the attending physic detached for use as the b	ystcian/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Mo 9 ☐ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
lures mar m n signed by	d by Ph		itions contributing to death but	not resulting in the t	underlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
iician: The law requires that certificate has been signed b rector, page 2 should be deta	Completed		-			24a. Was an autopsy performed?	24b. Were autopsy findings availa prior to completion of cause of death? 1 Yes 2 No
certificate	Be (25. Was case referred to medi examiner?			26. Place of D	eath (Check only one)	
Q. 5	2	1 ☐ Yes 2 No	Hospital: 1 Inpatient			Home 5 Residence	
or Attending Phater death. Director: After thin by the funeral	Certification:	L _ / tooldont	stigation	Year) 28b. Time (of 28c. Injury at Work? M 1 \[Yes 2 \] No	28d. Describe how inju	ury occurred
s after do	Certific	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	28e. Place of fnjun building, etc.	y - At home, farm, st (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical (examination and/or in	th occurred at the time, date and pla nvestigation, in my opinion, death oc		
To the To the comp	Me	29b. Signature and title of cert	fier O o	_ 00	29c. License number	,	ate signed (Month, Day, Year)
-	of the	me	- all	man war			000 / 2006
30		· ·	on who completed cause of dea	ath (Item 23a) (Type	Print)	01.10	ov 7 2006 m ide 330 Roden

Registrar

Physician

		1 - State of Maryla	nd / Depa <i>Cei</i>	artment of Health and rtificate of Death		giene 0 0 6	38236
A STATE OF THE STATE OF	gr.	1. Decedent's Name (First, Middle, Last)	-		2. Date of De	nath Day Year	3. Time of Death
Physicia /Medic		Doris Eleanore Ryden			11	27 2006	0942 a ^M
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea		4c. County of Dea	
2990 P.S.	V	1308 Gresham Rd. 5. Social Security Number 6. Sex 7. Age (In yrs	last hirthday)	Silver Spring If Under 1 Year If Under 24 Hi		Montgo	mery thplace (State or Foreign
Funeral Director	y I	474-24-3937 1□ M 2⊠F 89	. last birthday) Yrs.	Months Days Hours Mir			ou <i>ntry)</i> inesota
70		Usual Residence of Decedent					
arylar show dat	_	,	ity, Town or Lo ilver S				10d. Inside City Limits 1 ☐ Yes 2 🖾 No
he Mi	Director		TIVEL D			10g, Citizen of What C	
death with the Maryland ms 23a or 28a-f ehow critest be rediffed at	吉	100. Street and Number		10f. Zip Code 20904		USA	ountry?
leath	Funeral	1308 Gresham Rd. 11. Marital Status 12. Was Decedent Ever in	J.S. 13.	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No		erican Indian,
ē 2 2	by Fun	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	ŀ	If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2X No Specify:	rto Rican, etc.)	Black, Whi Specify: Wh	
2 hou		15. Decedent's Education	16a. Dece	dent's Usual Occupation kind of work done during most of w	arkina	16b. Kind of Business	/Industry
1215-UU36 within 72 hours aff nne. than "naturel", or the Madical Exami	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired)	Orking		
ygien ygien t. he	S	4	Nurs		/F' 187-14	Hospital	
yland ould be file Mental Hy arked oth attic event	Be	17. Father's Name (First, Middle, Last) Edwin Ephriam Lundahl			_{ame (First, Middle} Malmgren	, Maiden Sumame)	
rylg hould d Mer mark matic	ို	19a. Informant's Name/Relationship (Type, Print)	19b Mailir	ng Address (Street and Number or I			Zin Code)
Mand 2 si		John Charles Ryden/son		Belair Dr. Bowi			2.5 0000)
Te, Heal			Place of Dispo	position (Name of matory or other place)	Date Date	20c. Location - City or	Town, State
Page ent o nt: If		1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	hesapea	ke Crematory 12	-1-06	Beltsvi	11e, MD
Baltimore, permit. Pages 1 ar Department of Hea Important: If item eny injury or othe		21. Signature of Funeral Service Licensee mul.	358 2	2. Name and Address of FacilityRa	pp Funer		ion Service
		23a. Part1. Enter the disease, or complications that caused the decisions, or heart failure. List only one cause on each line.					Approximate Interval Between
Physician		Immediate Cause (Final disease or condition Paralysis					Onset and Death
/Medical		resulting in death) Due to (or as a conse	quence of):				
Examiner	_	Sequentially list conditions, if any leading to immediate		ression			
18t 18d	nlne	cause. Enter Underlying Cause (Disease or injury		th Metastasis to	the Sni	ne	
cate be executed physicien and the burial-fransit	Examine	that initiated events resulting in death) Last c. Due to (or as a conse		th hetastasis to	the bpi	II.E	
ate be e	dical E	d					
tificat g phy as th	ed						
S, P.O. BOX 60 es that the death certific igned by the attending p be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1☐ Live birth 2☐ Fe	nancy tal death 3[Ectopic pregnancy		23d. Date of de Month	livery Day Year
O. F. he dear the dear to	ls c	in the past 12 months? 1 □ Yes 2 ₩ No 9 □ Unknown 1 □ Yes 2 ₩ No 9 □ Unknown	death 5	Other (specify)		Month	Day Tour
hat the deby detack		Part II. Other significant conditions contributing to death but not re	sulting in the u	ndertving cause given in Part I	23e. Did	tobacco use contribute t	o the cause of death?
VItal Records, F.O sician: The law requires that the certificate has been signed by th	d by	The article of the state of the	John Jan Co	mostlying oddso given in race.			robably 4 Unknown
M require	Completed				24a. Was	an 24b Were a	utopsy findings available
The law	dmc				auto	psy prior to death?	completion of cause of
VITAL H sician: Th certificate rector, pag	0	25. Was case referred to medical		26. Place of D	1 ☐ Yes eath (Check only	*****	s 2 No
	To B	examiner? 1 ☐ Yes 2√2 No Hospital: 1 ☐ Inpatient 2 (☐ ER/Outpatier			dence 6 Other (Spe	ecify)
		27. Manner of Death 28a. Date of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day Year)	28b. Time o			how injury occurred	
ISIO Ittendii death. ctor: A y the fu	catl	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
S Fig d	ertification;	4 Homicide determined 28e. Place of Injury - At building, etc. (Spec	home, farm, sti cify)	reet, factory, office		'Street and Number or R wn, State)	tural Route Number,
spital ours a neral	O	29a. Certifier How Certifying Physician: To the best of my kr	nowledne dest	h occurred at the time, date and nia	ce, and due to the	cause(s) and manner a	s stated
• Hos 24 h • Fur	edical	(Check only 2 Medical Examiner: On the basis of examinations)	nation and/or in	vestigation, in my opinion, death oc	curred at the time,	date and place, and du	e to the cause(s)
To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	-	29c. License number		29d. Date signed (Mon	
^		10/10		D0064983		11-30-200	06
1.70		30. Name and address of person who completed cause of death (Itt					20002
		Kashif A. Firozvi MD 2101 Med) Silver	Spring MD 2	20902
Sta Regist		31. Date filed (Month, Day, Year) 32. Figishar's Sign	J. J.	parti			

		For State Registrar	State o		nd / De		t of He	alth and M	lental Hygid		38237
	3	Decedent's Name (First, Middle)	Last)	0	-				2. Date of Death	-	3. Time of Death
Physicia /Medic		Ameli	a	KON	ne	0			Month November	29, 2006	2:00 P M
Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City,	Town, or L	ocation of Death		4c. County of Dea	
		3501 Dudley	Avenue					ltimore		N,	/A
Funeral Director		212-03-4299	6. Sex 1 □ M 2 💢 F	7. Age (In yrs	s. last birtho	Months		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bir 1918	thplace (State or Foreign buntry) Maryland
and w		Usual Residence of Decedent 10a, State 10b, County		10c. C	City, Town o	r Location					10d. Inside City Limits
Maryl f sho	ঠ	Marral and	τ / Λ			Balti	mo.r.o				1 No 2 No
the 28a	Director	Maryland Number	V/A			10f. Zip			100	. Citizen of What Co	ountry?
3E or		3501 Dudley Ave	7110					213		U.S.	
death ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in	U.S.	13. Was Deced		panic Origin? (Spe Mexican, Puerto	ecify Yes or No-	14. Race - Ame	erican Indian,
after or Ite	Ē	1 ☐ Never Married 2 ☐ Marri	Armed For ed 1 ☐ Yes If Yes, Gir	2 🔀 No		1 ☐ Yes			Rican, etc.)	Black, Whit	e, etc.
ural',	d by	3 ∰Widowed 4 ☐ Divorced	Year or D	ates:		1 1 1 1 1 1 1 1	5편 140	Specify:		Specify:	White
within 72 hours after death with the Maryland ene. I than 'natural', or Items 23s or 28s-f show to M. drail Examiner must be notified al	Completed	15. Decedent (Specify only highes	s Education I grade completed)		(0	ecedent's Usua live kind of wor	k done dur	on ring most of worki	ing 16	b. Kind of Business	/Industry
withir than	E G	Elementary/Secondary (0-12)	College (1-4or 5+)	11.	fe. DO NOT us				Own 1	Iomo
Hygie Hygie of ther		6th Grade 17. Father's Name (First, Middle, L	ast)			HOME	emake:		e (First, Middle, Ma		nome
ld be ental ked o	To Be	Edmund Urbansk	i						a Kopycii		
shou ind M s mar umat	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. N	lailing Address	(Street and	d Number or Rura	al Route Number, (City or Town, State, .	Zip Code)
and 2 alth a 27 is er tra	3	Edmund Romeo (S	on)		3	508 Ch	ester	field Av	e., Bal	timore, Mo	1. 21213
of He of He fiten roth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 Demoval from		Place of D cemetery,	isposition (Nan crematory or o	ne of ther place)		Date 20	c. Location - City or	Town, State
Pag ment ant: I		'4 □Donation 5 □Other (Sp			yview	Cremat				altimore,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, Ite M. Jical Examinet must be notified at once.		21. Signature of Funeral Service L	icen ee			22. Name an 3331 B:	d Address rehms	of Facility Sch Lane, B	imunek Fu altimore	uneral Hor , Maryland	ne Inc. 1 21213
	1	23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that conly one cause on a	aused the de		enter the mod	e of dying,	such as cardiac o	or respiratory arres	t,	Approximate Interval Between
hysician		Immediate Cause (Final disease or condition resulting in death)	a	150	the	MIC	he	art	disea	se	On let and Death
/Medical Examiner		resulting in death)	Due to	(or as a conse							
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cuted	Examiner	that initiated events	G.								
be executed ician and burial-transit	Ex	resulting in death) Last	Due to	(or as a conse	equence of)						
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entific ding p	/Med	IF FEMALE:	23c. If yes, ou	toom a of progr	nano:						
death certificate e attending phys d for use as the	slan	23b. Was decedent pregnant in the past 12 months?	1 Live t	ointh 2 ☐ Fe nant at time of	tal death	3 ☐Ectopic pr 5 ☐ Other (sp				23d. Date of del Month	ivery Day Year
ires that the death certificate be executed signed by the attending physician and does detached for use as the burial-transit	Physician/M	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9□ Unkn		douth	3 - Other (sp	ocny)		-3910		
The law requires that the ate has been signed by the bage 2 should be detached.	by Pl	Part II. Other significant conditio	ns contributing to d	eath but not re	esulting in th	e underlying c	ause given	in Part I.	23e. Did toba	cco use contribute to	the cause of death?
v require been sig should b	eted b								1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Wunknown
law requ	plet	[[24a. Was an autopsy	24b. Were au	itopsy findings available
	Comple								performe	d?/ death?	2 No
Physician: this certific ral director,	Be	25. Was case referred to medical examiner?							Check on one		
≥ .20 ⊅	은	1 ☐ Yes 2 € No			☐ ER/Outpa					ce 6 □Other (Spe	city)
ding Phys h. After this funeral di	tlon	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig		th, Day Year)	28b. Tim Inju		8c. Injury a Work?	t s 2 □No	28d. Describe how	injury occurred	
Attender deat	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place	e of Injury - At	home, farm	, street, factory			28f. Location (Stre	et and Number or Ru	ıral Route Number.
s after s after al Dire	Certification:	4 Homicide	build	ing, etc. (Spec	cify)				City or Town, :	State)	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying (Check only one)	xaminer: On the b	best of my kr asis of examir iner stated.	nowledge, d	eath occurred ir investigation,	at the time, in my opin	date and place, a sion, death occurre	and due to the cau ed at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	, lv	m	-	290	License n	L573	3 290	Date signed (Monti	h, Day, Year)
6		30. Name and address of person v	vho completed cau	se of death (Ite	em 23a) (Ty	pe, Print)	-		ID		1
w		DUNC	AN	SA	M	2 N	> と	501 L	och 14	ven b	IVd
Sta Registr		31. Date filed (Month, Day, Year)	32. F	legistrar's Sigi	nature	frank.	,			2 123	9
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ROMCO, AMCLIA Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, &

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Robert James Reimer November 28, 2006 10:26 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Franklin Square Hospital Center Rosedale Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 12,1951 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1√ M 2□ F Months Hours 214-56-5097 55 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Ite Modical Examinar must be notified at Maryland Baltimore Baltimore 1 Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? u.s.A. 17 Fuller Avenue 21206 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ¼Yes 2 ☐ No If Yes, Give 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be tiled within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itel may injury or other traumetic event, Ite Marical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♥ No Specify: White þ 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Shipping Co. 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be M. Reimer Tyminski Joseph George Agnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes M. Reimer (mother) 17 Fuller Avenue, Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 12/2/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arterioselevatic Cardiovascular Disease Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner?

1 ★ Yes 2 □ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) Signature and title of certifier 29c. License number 29h Housem ber 29, 2006 of death Item 23a) (Type, Print) 84 Trimble Hill CT. Lutherville, Md.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day SAUNDERS **Physician** November 29 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 24, 1931 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🔀 F Yrs. South Carolina 237-38-1378 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r 28a-f show notified at 10a. State 1 ☐ Yes 2X No Sparrows Point Maryland Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examiner must be r 21219 USA 2416 Wythe Avenue Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

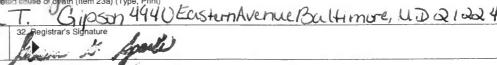
1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0036 "natural", or Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Own Home Housewife 12 years Department of Health and Mental Hyg Important: If Item 27 Is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Health and Mental H iant: If Item 27 Is marked oth Agnes Baxley Boyd McCaskill Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2416 Wythe Avenue, Sparrows Point, Maryland 21219 Husband Omeria Saunders 20b. Place of Disposition (Name of December 20c. Location - City or Town, State 20a. Method of Disposition Belair Memorial Gardens 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Balair, Maryland 4 □ Donation 5 □ Other (Specify) 2, 2006 21. Signature of Funeral Service Licensee Connectly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 complications that caused the deaty Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease of shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) ROKE Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gauss (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death c-rtificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1□ Yes 2 death? 1 ☐ Yes 2 No 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of



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November 29 2000

		1	For State Registrar	State of	Maryland		ertment of F rtificate of	Health and I Death		giene 2	006	3824	0
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5-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notifled at	ted	15. Decedent's	Education		16a. Deced	dent's Usual Occu	pation during most of wo	rkina	16b. Kind of	Business/Ind	lustry	
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Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	2	WALTER BROWN					MAMMIE	BROWN				_
ar	2 shc and is m		19a. Informant's Name/Relationshi	p (Type. Print)		19b. Mailir	ng Address (Stree	t and Number or R	ural Route Numb	er, City or Tov	vn, State, Zip	Code)	
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		21. Signature of Fundal Service Li	cepse	_	W. 3	2. Name and Addr M C BROW 21 S PHI	ess of Facility N COMM FU LADELPHIA	JNERAL HO	OME-HAF ABERDEE	RFORD, EN, MD	P.A. 21001	
	3 -		23a. Part1. Enter the disease, or construction shock, or heart failure. List of	omplications that ca	used the death.	. Do not en	ter the mode of dy	ing, such as cardia	c or respiratory a	rrest,		Approximate Interval Between	
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	9		30. Name and address of person v	vho completed cause	e of death (Item	23a) (Type	, Print)						
	-		Bernadette C SIO	Hon MD	22 SU 114	L gree	ne street	Bathmon	re Mav	yland	2120	1	
		ate	30. Name and address of person of Berna Actte C Sto 31. Date filed (Month, Day, Year) DEC 0 1 2	0.00 A 2. Re	egistrar's Signa	ture	Les .						
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State of Maryland / Department of Health and Mental Hygiene [] [] 38241 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 20, Month **Physician** November 2006 Shirley Sanford 9:00 A M Patricia Dorris /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Co. 409 Westfield Road Dundalk If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖫 F Min Yrs. Director 71 Dec. 29,1934 212-34-8484 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rthen "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Dundalk 1 ☐ Yes 2 XNo Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21222 409 Westfield Road Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Heelth and Mental Hygiene. int: If item 27 is marked other then "natural", or items 23. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth L. Mays Leslie L. Martin ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4206 North Point Road Dundalk, Maryland f Health item 27 i Deborah Isner (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Figure 1 in Ite eny injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/24/2006 Parkwood Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Lung Cancer 5 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, flary, backing to minimodale cause. Enter Underlying Cause (Disease or injury Due to (or as a consequents of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Sivision of Vital Records, Be Completed by Cerebrovascular Disease No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an autopsy performed? Yes 2 No 1 Yes 1 Tyes 2 No Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 28a. Oate of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 XNatural 5 Pending within 24 hours after death.

To the Funeral Director: Aft 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24356 21237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9103 Franklin Square Drive Suite#2200 Baltimore, MD William C. Waterfield, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature Registrar

			For State Registrar		Stat	te of Ma	ıryland	d / Dep <i>Ce</i>	artmer rtificat	nt of H	lealth Deati	and M h	lental Hy	/giene		06	3824	2
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	Regist			DEC 0	1 2006	32. Togistr	ر مری	15 A	MARKE	9								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year November 29, 2006 **Physician** 5:23 P Loretta A. Shannon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Blakehurst Care Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 27,1918 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🔀 F West Virginia Sept. Director 88 215-18-8327 Usual Residence of Decedent 10c. Cify, Town or Location or 28a-f show notified at 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 21204 USA 1055 West Joppa Road # 743 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) C&P Telephone Drafting Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Estella A. Kitzmiller Charles L. Kibler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1055 W. Joppa Road, #743, Towson, MD. of Health Daniel J. Shannon (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/04/2006 o <u>=</u> permit. Pages Department of Important: If it any Injury or c 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 Stephen Coster 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CAMPLICATIONS 4 cars disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate if any leading to immedia cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The hours after death. Funeral Director: After this certificate tely filled in by the funeral director, pag 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Nermber 30 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N, Charles ST POWSIN ND ZIROY CHARLES, MD 6565 Anon

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature



		1	For State Registrar	State of Marylan		rtment of H tificate of L			jiene 006	38244
			Decedent's Name (First, Middle, Last)			-		2. Date of Dear		3. Time of Death
	Physicia		Freder	cick W. S	chech			Month NOV	Day Yea 30 20	MA NA
	/Medic Examin		4a. Facility Name (If not institution, give str			4b. City, Town, or	Location of Death		4c. County of De	
	Lxamm	CI	2707 Judy Court			Fink	sburg		Car	roll
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. E	irthplace (State or Foreign Country)
	Director		215-07-7475	M 2□F 88	Yrs.	Working		July 1	1,1918 1	Maryland
	2		Usual Residence of Decedent	10c Cit	v. Town or Lo	ration				10d. Inside City Limits
9	h h	_	10a. State 10b. County MD Baltin		Ess					1 ☐ Yes 2 ☑ No
1	88-1- 1	Director		ЮТС					l Og. Citizen of What	
4	or 2	ā	10e. Street and Number 207 Sandhill Co	+		10f. Zip Code	2.1		•	Country
4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8 23e	Funeral		2. Was Decedent Ever in U	C 13 V	2122		acify Yes or No-	USA 14. Race - Ar	merican Indian,
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land	Mental Mental Marked o	To B	Ignastius E. S	chech			Kather	ine Sp	iegel	
a	E DE E		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailin	g Address (Street a	and Number or Rura	al Route Numbe	r, City or Town, State	a, Zip Code)
Σ :	and 2 ealth a n 27 io		F. Glenn Sched		207	Sandhil	11 Court	Balti	more MD	21221
e e	of He		20a. Method of Disposition		Place of Dispo cemetery, cren	sition (Name of natory or other plac	(a)	Date	20c. Location - City	or Town, State
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	/Medical		resulting in death)	Due to (or as a consec		r. Liver	210000			- yau
	Examiner		Sequentially list conditions, b.							
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ý ×	leati certific attending p	Me	IF FEMALE:	ic. If yes, outcome of pregn	ancu				and Date of	dethics
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o o	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of a 9☐ Unknown	1 0 am 5	Other (specify)				
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<u>~</u>	cate pag	S						1 Yes	2 No 1 1	
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<u>s</u>	Attending Physician: or death. ector: After this certification in the funeral director,	cal	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	nome farm str			28f. Location (S	Street and Number of	Rural Route Number,
<u>.≥</u>	after Direction by	Certification:	4 Homicide determined	building, etc. (Spec	ify)	00,, 100,0,7, 0,1100	ļ	City or Tow	vn, State)	
_	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier Certifying Phys	ician: To the best of my kn	owledge, deat	n occurred at the tir	me, date and place,	and due to the	cause(s) and manner	as stated.
	24 h 24 h Fur etely	Medicai	(Check only 2 Medical Examin one)	er: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	pinion, death occur	red at the time,	date and place, and	due to the cause(s)
	within 2 To the complet	Me	29b. Signature and title of certifler			29c. Licens	e number		29d. Date signed (M	onth, Day, Year)
	- > - 0		1106	sel		/) 2	1660		11/3/	106
	- 4		30. Name and address of person who col	mpleted cause of death (Ite	m 23a) (Type.	FR-1-sh			, ,,,,,	1
	6		Thomas K. Gali	WIE 291	Stone	IN A De	Wes	TMINS	ter. M	1) 21157
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	N. a	,		1./	
	Regist		DEC 0 1 200	6 Elleus A	3. AD					

SANDER ISABELLE

NOVEMBER

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0 1

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Non **Physician** 1025 AM Thompson Thelma 2006 28 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayuew Baltimore Baltmore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**Z**F Yrs. 214-12-2160 84 Director March 31,<u>1922</u> Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 →No Harbor View Park Maryland Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Iteme 23a or 704 South 49th Street 21224 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specity: Specify: ۵ 3 ₩Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Assistant Manager G.C. Murphy's Store 10 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil timent of Health and Mental H tant: If item 27 is marked ott jury or other traumatic even Be Anna Robb Frank Roden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21221 323 Ida Ave. Baltimore, Maryland Mrs. Ida M. Havart (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment o Important: If any Injury or once. 12/2/2006 4 □ Donation 5 □ Other (Specify) Oak Lawn Cemetery Baltimore, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland lover 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Renal tallyre **Physician** /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the Inneated Inneated director. Page 2 should be detached for use as the buriat-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 **爰**Ûnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 28 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Territying Physiciam. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner ac etated.

Zight Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated dure and trie of certifie 29c. License number RES-000 NOV, 28 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 LOLA A. FASHOYIN, MO 4940 EASTERN AVENUE GALTIMORE MD 21224 32. Restrar's Signature 31. Date filed (Month, Day, Year) Registrar

			- For Amend Items Registrar	State of Marylan 23a, 25, 27, 28a 20c, per FH	d/Depa - f per	artment of H	lealth and Death	Mental Hyd 6dhb	giene 2 () Reg. No.	06	38247
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea	ath Day	Year	3. Time of Death 2 P M
	/Medic Examin	al	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of De		4c. County	of Death	2 1
	Examili	ei A.	GOOD SAMA	RITAN HOSPI	TAL		ALTIMO		NIA		
*	Funeral Director		5. Social Security Number 6. Social Security Number 1 219-32-8549 Usual Residence of Decedent	ex	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		y, Year) 1934	9. Birthplac Country	ce (State or Foreign
	Maryland	tor	10a. State 10b. County	_	y, Town or Lo					100	1. Inside City Limits
	or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country	y?
	a 23a	eral [3915 Calloway	Ava Apr 500	-	21211		(Specify Yes or No	USA 14 Bac	e - Americar	Indian
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f ehow important: If item 27 is marked other than "natural", or Itema 23a or 28a-f ehow appring or other treumatic event, the Medical Exam fact must be notified at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marned 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba	an, Mexican, Pue	erto Rican, etc.)		ck, White, etc	с.
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Maryland	d 2 shi th and 7 is m treum		19a. Informant's Name/Relationship (7	Type, Print)	11	ng Address (Street		Rural Route Numbe	CONTRACTOR OF THE	VI	
	f Heali tem 2 other		20a. Method of Disposition	20b. F		osition (Name of matory or other place		Date	20c. Location	· City or Tow	n, State
Baltimore,	Page nent o ant: M ury or		NBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State			/ 1	hatman	Crownsv	ile Co	m. Md
3alti	permit. Departrimports imports eny inju		21. Signature of Fineral Service Live	99				_			
	00.5 • 0	4	23a. Party. Enter the disease, or com	Dications that caused the deat	h. Do not en	ter the mode of dvir	ers tow	Rd Ba	rest.	_ Md &	21215 Approximate
	Physician /Medical	-	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	EPSIS	- Disease	complic	erotic Ca cated by (ardiovas Cecal Pe	scular erfora	nterval Between Onset and Death Lion
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	certificate be executed iding physician and ise as the burial-transit	Examin	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):		Mary	L CHURCH	LEXAMINER		
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	w requires that the sbeen signed by the should be detached	۾	Part II. Dther significant conditions of RENA	contributing to death but not res	ulting in the u	inderlying cause giv	ren in Part I.		obacco use cont Yes 2 ☐ No	tribute to the	cause of death?
Division of Vital Records,	The law ate has b page 2 st	Completed							osy ormed?	Were autops prior to comp death? 1 Yes 2	sy findings available bletion of cause of
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		O#	000	eath (Check only o			
0	Phys or this oral dis	7: To	1 XYes 2 No	28a. Date of Injury (Month, Day Year)	28b. Time o	III JUDON	4 INUISING		how injury occur	red	•
io.	ath. ath. ir: Afte	atio	1 ☐ Natural 5 ☐ Pending investigation	10/18/2006	Unkno		Yes 2 No	Bowel pe	eriorati ostic pr		
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (nysicien: To the best of my knominer: On the basis of examination and manner stated.				ice, and due to the		anner as stat	
	of this of the composition of th	Me	29b. Signature and title of certifier	er MD		29c. Licens		1	29d. Date signe		ay, Year)
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	F > F 0						5 000			29.2	
7	Ì	ate	30. Name and address of person who Kuman Sujection 31. Date filed (Month, Day, Year)	completed cause of death (Iter MD 5601 LL 32. Registrar's Signa	n 23a) (Typa						

Thomas, CORA

Earl W. Tuckey 11/25/2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygi

Hygiene		\cap	5	3	Ω
Bea No	U	U	U	U	U

		1 - For State Registrar	Otato or mi	Ce	rtificate of			Reg. No.	006	38248	3
Physic	cian	Decedent's Name (First, Middle, La Earl W Tuckey Sr	st)	- 3-			2. Date of De Month November	ath	ne Year	3. Time of Death	_
/Med	lical	4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Death			ounty of Death	8:00am M	1
Exam	mer	1245 Linkside Drive	,		Baltimon				ltimore		
Funera Directo		EEO 10 7 100	Sex 7. Age 7. Age 81	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da February	th 19, Year) 20 192	9. Birthol Coun. 25 Baltir	lace (State or Foreign try) nore City, M	n 1c
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10	0d. Inside City Limits	3
the Marylar 28e-f show	tor	Maryland Baltimore		Baltimore (County					1 ☐ Yes 2 🙀 No)
th with the 23a or 28	Funeral Director	10e. Street and Number 1245 Linkside Drive			10f. Zip Code 21234			10g. Citizer	n of What Coun	try?	
1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health and Mental Hygiene 1 Item 27 ie marked other then "neturel", or Items 23a or 28a-f show other treumatic event, the Modified Exam or must be reciliable	þ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Everin U.S. 13. No UM II	Was Decedent of HI Yes, specify Cub	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		Race - America Black, White, e pecify: Whit	etc.	
72 ho	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	nation during most of wor	king	16b. Kind	of Business/Ind		
within ane. Ithen	ldm	Elementary/Secondary (0-12)	College (1-4or 5	+) Drafts		d)		MDC Co	***		
filed Hygie other	ပိ	17. Father's Name (First, Middle, Last		Drarce	SIICI I	18. Mother's Nam	ne (First, Middle,	MRC Co			-
uid be Jental rked tic ev	To Be	George Harvey Tuckey				Almira To	lson				
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then eny injury or other treumatic event, ILL Many on the contract of the contract		19a. Informant's Name/Relationship (Carolyn K Tuckey (Wi			ng Address <i>(Street</i> 5 Linkside (Code)	
Pages 1 and 2 lent of Health a nt: If item 27 ie		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ 1 □ Donation 5 □ Other (Special		_	osition (Name of matory or other pla natory Inc	1	2006		tion - City or To nore ,Mary]		
permit. F Departm Importar eny injui	ġ	21. On an Ire of Funeral Service Cice			2. Name and Addre Lassahn Fund			DOLOM	ore jiring.	LLI IO	_
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cien: ertifica actor, p	Be	25. Was case referred to medical examiner?				26. Place of Dea				<i></i>	_
Physic this c	10	Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie			4 Nursing H	ome 5X Resid		Other (Specify)	
ding th. After	tlon	1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injui (Month, Da)	Year) Injury	Wo	rk? Yes 2 □ No	200. Describe r	iow injury of	ccurred		
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	3 Suicide 6 Could not b	e 290 Place of this	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (S City or Tox		lumber or Rural	Route Number,	_
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		C) In-	I CML	Leputy	118	5667		Nove	nber 2	7,2006	
104		30. Name and address of person who	P QW'9	e Trimb	Print) 4:11	3667 CT. Lut	Lewille	Mi	015 (93	
S Regis	tate strar	31. Date filed (Month, Day, Year) DEC 0 1	32. aghetra	ar's Signature	melle			•			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 27, 2006 **Physician** November 6:45A Iona Marge Ulbia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore N/A 3239 Pelham Avenue If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 Ø F Months Hours Yrs. Director 220-14-7618 80 9. Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c, City, Town or Location 10a. State 10b Counts 10d. Inside City Limits in then "naturel", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 □ No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3239 Pelham Avenue 21213 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 🕱 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress V. F. W. 8th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alberta Nixon Charles Valentine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herman A. Ulbig (Husband) 3239 Pelham Avenue, Baltimore, Maryland 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 12/01/2006 Baltimore. Maryland Gardens of Faith 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. Comes 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cancer KN OWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ettending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☑ No 1 Yes 2 No ieral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Eutaw St. Bulfimore,

DHMH 17 Rev 1/2001

10

Registrar

State

ISO MD 31. Date filed (Month, Day, Year)

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2006

Richer Hospica

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			1 - For State Registrar				ent of H	ealth and M	lental Hy	giene () (Reg. No.	38250
	Physici	ian	Decedent's Name (First, Middle, La		Elizabe	th s	/irqin		Month Novemb	Day	3. Time of Death 5:15 A M
	/Medic Examir		4a. Facility Name (If not institution, gir					Location of Death	Novemb	er 28, 2	2006 M
	Exami	lei	981 Topview Drive				Edgev			Hari	
	Funeral Director		5. Social Security Number 6. 3 220-24-9262	Sex 7. Ag	ge (In yrs. last bii 89	Yrs. If Un Mont	nder 1 Year hs Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) Feb. 2	h v, Year)	Birthplace (State or Foreign Country) Maryland
	ter death with the Maryland tems 23a or 28e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Harfe	ord	10c. City, Tow	m or Location		Edgewood			10d. Inside City Limits
	vith th	Dire	10e. Street and Number			10f.	Zip Code			10g. Citizen of W	/hat Country?
	s 23s	- La	981 Topview D	7	Ever in 11 C	12 W D-		LO40	anti-Van ar Na	United	States - American Indian,
) 036	or its	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Amed Forces 1 Tyes 2 X If Yes, Give Year or Dates:	?		specify Cubai	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)	Specify	k, White, etc.
215-0	ges 1 and 2 should be filed within 72 hours 1 of Health and Mental Hygiene. If Item 27 is marked other than "neturel", or other traumatic event, the Medical Exp	npleted	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or		Decedent's U (Give kind of life. DO NO	Jsual Occupa work done d Tuse retired;	ition luring most of work)	ing	16b. Kind of Bu	
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	ould Men harke	2	Henry P. White						Hohman		
Mar	12 sh h and 7 is m traum	1	19a. Informant's Name/Relationship Dorothy Sell	(Type, Print) (Daughter)		o. Mailing Addr 181 Top		nd Number or Rur โทร์ พล โกลี		n, City or Town, Marylar	
. e	Healt		20a. Method of Disposition	(Daugircer)	20b. Place o	f Disposition (Name of	!	Date		City or Town, State
38 (Pa men ant: ury		1 Burial 2 □ Cremation 3	fy)		Lawn Ce		12/	1/2006	Baltin	more, Maryland
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dd Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0.00	Tout	26. Place of Deat			
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_	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. License	number		29d. Date signed	(Month, Day, Year)
	/		30. Name and address of pers in who	completed cause of	death (Item 23a)	(Type Print)	40	06313	8	11/2	8/06
	5		Jeffrey Sw.	ett 500	Upper	Ches	apea	Ke Or.	Beld	liam	021014
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			Anne Arundel 5. Social Security Number		7. Age (In yrs.	last hirthday)	Ann If Under	apol	1S If Under	24 Hrs.	8 Date of Birth		Aru	
	Funeral Director		009-12-3030	1 M 2 M F	83		Months	Days	Hours	Min.	8. Date of Birtl (Month, Day 05/06/	Year)	Cou	place (State or Foreign ntry) VT
			Usual Residence of Deceden	t							03/00/	1925		<u>V</u>
	arylan show	_	10a. State 10b. Con	e Arundel	10c. Cit	y, Town or Lo	_{cation} en Bu	rnie						10d. Inside City Limits 11 Yes 2 No
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Ball	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Sen	vica Licensea	roll	_ C	harle 501 E	s L.	Ste	vens	Funeral	L Home	Inc.	21230
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n o		iuo	27. Manner of Death 1 ─ Natural 5 □ Pe	riuling	f Injury h, Day Year)	28b. Time o Injury		8c. Injury Work	?		28d. Describe h	ow injury occu	rred	
Sic		icat	3 ☐ Suicide 6 ☐ Co	vestigation	of Injury - At he	ama form et	M		'es 2□		19f Location (S	treet and Num	ther or Pur	al Route Number.
Division	spitel or At ours after o nerel Direct filled in by	Certification:	4 ☐ Homicide de	termined 286. Flace buildin	ig, etc. (Specif	y)	eet, ractory	, опісе		2	City or Tow		iber or nur	ai Hobie Number,
_	Hog Fur Tely	edlcal C	29a. Certifier 1 Cert	tifying Physician: To the lical Examiner: On the ba and mann	sis of examina	wledge, deat tion and/or in	n occurred a	at the time in my op	e, date an inion, dea	id place, a	and due to the co	ause(s) and mate and place	nanner as s , and due t	stated. o the cause(s)
\	To the Hos within 24 hr To the Fur completely	Me	29b. Signature and title of co	Marken	40			License	number	· 6		9d. Date ofgn		
	N		39. Name and andress of per	rson who completed cause	of death (Item	11 . 11	Print)	Par	<u></u>		Amat	11/2 olis 1	D 2	-1401
	Sta Registi		31. Date fied (MDE Pay, Y	(ear) 32 Ae	egistrar's Signa	iture	ecel	, ιω,	- I-w	7.	· · · · · · · · ·	- / \		
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Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of Mar	yland / D	epartment <i>Certificate</i>	of Health a	and Me		giene 20	06	38252
			1. Decedent's Name (First, Middle, Las	st)				2.	Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medio		Larry E.		Willis			N	ovemb		006	6:00 P M
-01	Examin		4a. Facility Name (If not institution, give	e street and number)	1 1	4b. City, T	own, or Location	of Death		4c. County of	of Death	
			+ ranklin Sque		ellen	hday) If Under 1	Year If Under	3/4	5	139		nose
	Funeral		5. Social Security Number 6. S 216–54–3735	ex ∦.Age (M∑M 2 □ F	(În yrs. last birt 57		Days Hours	Min. De	Date of Birtl (Month, Day	1 1948	9. Birthplai Country Virgin	ace (State or Foreign
	Director		Usual Residence of Decedent					-		17.520	VII.GII.	ша
	yland		10a. State 10b. County	1	10c. City, Town	or Location					100	d. Inside City Limits
	n the Maryland r 28a-1 show thytillied at	ţ	Maryland N/A		Balt	imore						1X Yes 2 No
	or 28	lrec	10e. Street and Number			10f. Zip 0				10g. Citizen of W	hat Countr	у?
	within 72 hours effer deeth with the Maryland ene. then "natural", or Itsms 23s or 28s-1 show the Madical Exercion rount be notified at	Funeral Director	937 Armistead Way				1205			USA		
	tems	nue.	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was Decede If Yes, specif	nt of Hispanic Ori y Cuban, Mexicar	igin? (Specif n, Puerto Ric	y Yes or No- an, etc.)	14. Race Black	- Americar , White, et	
36	s efte	by Fi	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	1 🗆 Yes 2]	No Specify:			Specify:	Whit	:e
-0036	tural	ed	15. Decedent's Ed		16a.	Decedent's Usual	Occupation			16b. Kind of Bus	siness/Indu	ıstrv
2/45	n na	plet	(Specify only highest gra			(Give kind of work life. DO NOT use	done during mos	st of working				,
7 212	d with piene	Completed	Elementary/Secondary (0-12) 10 years	College (1-4015+)	,	Never W	orked			N/A	L.	-
Da de	be filed withintal Hygiene. Id other therework, the Newerl, the Newerl, the Newerl	Bec	17. Father's Name (First, Middle, Last))						Maiden Sumame)	
Larr	uld by Venta	10 E	Darrell Willis				La	ura Mu	ıllins			
ary (ges 1 and 2 should be f t of Health and Mental F If itsm 27 is marked of or other traumatic sve		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (-		
N.	and and no no no true		Laura Willis	mother		7 Armist						1205
ore	of Hi		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	cemeter	Disposition (Name y, crematory or oth	er place)	Decemb	er	20c. Location - (
Ë	Pag ment tant;		4 ☐ Donation 5 ☐ Other (Specify	y)	Gardens	of Faith C		4, 200		Rosedale		ryland
Ball	permit. Pages Depertment of Important; if i any injury or once.		21. Signature of Funeral Service Licer	C. Con	nelle	7110 S	Address of Facility Funer ollers P	Point F	Road, ∶	Dundalk,	P.A. MD. 2	21222
			23a. Part1. Enter the disease, of com shock, or heart failure. List only	plications that caused the	he death. Dog	ot enter the mode	of dying, such as	s cardiac or re	espiratory ar	rest,	l Ir	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	. C.D	PI							Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence	of):						
	Examiner		Sequentially list conditions.	b								
09	, E	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	of):						
B.	executed in and rial-transit	Kam.	that initiated events resulting in death) Last	c. Due to (or as a	consequence	of):			-		-	
8760,	be ey			200 10 (01 00 2	3311334331133							
387	physicate sthe	dlcal		_ d								
9 X	Attanding Physician: The law requires that the death certificate be executed or death. setor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d. Date	of delivery	v
Вох	atter d for u	Car	in the past 12 months?	1□Live birth 2 4□Pregnant at ti		3 □Ectopic pre- 5 □ Other (spe-				Mon		Day Year
P.O.	t the d by the ached	hysi	9 Unknown	9 Unknown								
σ.	res that igned b	by P	Part II. Other significant conditions of	contributing to death but	not resulting in	the underlying car	use given in Part I	l.	23e. Did to	bacco use contri	bute to the	cause of death?
r p	w require been sig should b								161	es 2 No	3 Probab	bly 4 □Unknown
o O	aw requis been 2 should	plet							24a. Was		ere autops	sy findings available pletion of cause of
æ	The la	Completed							autop perfor	med? de	eath?	Plettori of Cause of
Division of Vital Records,	i cian; Th certificate rector, pag	Bec	25. Was case referred medical examiner?				26. Place	e of Death (C				
>	nysicia nis cert i direct	5	1 ☐ Yes 2 ☐ No	Hospital: 1 Impatient	t 2□EFVOu	tpatient 3 DOA	Other: 4 Nu	ursing Home	5 🗆 Resid	ence 6 🗆 Othe	r (Specify)	
0	ding Phy n. After this funeral c	ü	27. Mann of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	28b. 1 Year) II		c. Injury at Work?		I. Describe h	ow injury occurre	id	
Sio	ttandii death. stor: A / the fu	catle	2 Accident investigation			М	1 Tes 2					
Σ	or Attendestible of the destroy of the first	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.		rm, street, factory,	office	28f	Location (S City or Tow	itreet and Numbe m, State)	r or Rural F	Route Number,
۵	spital cours en nersi D	ပိ	On Continue of Continue Di									
	To the Hospital within 24 hours e To the Funeral Completely filled	ledical	29a. Certifier 1 ☐ Certifying Pt (Check only 2 ☐ Medical Examone)	nysician: To the best of miner: On the basis of a and manner state	xamination an	d/or investigation, i	n my opinion, dea	ath occurred	at the time, o	date and place, a	nd due to th	he cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and little of pertifier		-	29c.	License number			29d. Date signed	(Month, Da	ay, Year)
	⊢ \$ ⊢ ō					in	55 no	24		11. 7	20-	ay, Year) 00 1, 21337
	1.		30. Name and address of person who	completed cause of dea	ath (Item 23a)	Type, Print)	JJ US	5 7		111.5	,0-	00
	4			naway 91	000 Fr	anbling	Square	Driv	e Pro	Himore	- mn	1,21337
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	freels)	9		100		11112	
	Regist	rar	DEC 0 1 2	2006 Miller	JU.	The same						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6

		•	For State Registrar	,	Cer	tificate of Dea	th	Reg.	No.	00200
			Decedent's Name (First, Middle, Last)				2.	Date of Death		3. Time of Death
П	Physici /Medic			Martin Grant	3	Willhide]		Day Year 26,2006	10:30PM
	Examin		4a. Fecility Name (If not institution, give s	reet and number)		4b. City, Town, or Location	on of Death		4c. County of Deat	h
			8911 Hinton Avenu	e		Edgemere	e		Baltimo	ore Co.
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year II Und Months Days Hour	rs Min.	Date of Birth (Month, Day, Ye	ar) Co	hplace (State or Foreign untry)
	Director		216-24-4831	76	Yrs.		F	eb. 14,1	.930 Mai	cyland
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	lanyla eho	ŭ		timore				Edgemere		1 ☐ Yes 2 ☐ No
	the N	Director	10e. Street and Number	CIMOLO		10f. Zip Code			Citizen of What Co	untry?
	with					·	07.0			,
	eath	Funeral	8911 Hinton Ave	nue 2. Was Decedent Ever in U.S.	13 V		219 Origin? (Specif		United S1	
	ther d	Ë	1 Never Married 2 Married	Armed Forces?	li li	Vas Decedent of Hispanic Yes, specify Cuban, Mexi	ican, Puerto Ric	an, etc.)	Black, White	
8	urs al	by	3 ⅓Widowed 4 ☐ Divorced	1 TYes 2 No If Yes, Give 1947-5 Year or Dates:	51 1	☐ Yes 2☐ No Spec	cify:		Specify:	White
Ď	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-f ehow he Mudical Estarili or mail te molified at	Completed	15. Decedent's Educ	ation	16a. Deced	ent's Usual Occupation		16b	. Kind of Business/	Industry
2	thin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)	nost of working			
2	gen gen er th	Son	ll Years			ool & Dye Se			Manufact	uring
2	al Hygid I other	Be (17. Father's Name (First, Middle, Last)			18. Mo	other's Name (F	irst, Middle, Maid	den Sumame)	
Maryland 21215-0036	Ment Ment arked	၉	John Elison Wil			(Catheri	ne Mary	Weber McV	Villiams
a L	2 should be i and Mental I is marked o raumatic eve	. 39	19a. Informant's Name/Relationship (Type			g Address (Street and Nur				
	2 5 5 5	1	Sandra Willhide-Mc			Taylor Road	1			
ore	Jes 1 of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐ Re	Cen	ce of Dispo netery, cren	sition (Name of natory or other place)	Date	200	. Location - City or	Town, State
Ξ	Pages ment of ent: if it		4 □ Donation 5 □ Other (Specify)	Hill	Ltop S	Service Corp	. 11/30	/2006 T	owson, Ma	aryland
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		21. Signature of Funeral Service License	е	22 D1	. Name and Address of Fa Ida-Ruck Fund	eral Ho	me of Du	ndalk. Ir	nc.
_	0 □ = 0		Just a Jone			922 Wies Ave	e. Dunc	lalk, Ma	ryland 2	1222
			23a, Fart1. Enter the disease, or complice shock, or heart failure. List only on	eations that caused the death. e cause on each line.	Do not ente	er the mode of dying, such	n as cardi <i>a</i> c or re	espiratory arrest,	+	Approximate Interval Between Inset and Death
S	Prysician		Immediate Cause (Final disease or condition resulting in death)	Acut	the	Mrsky.	wsi	BOK WA	Ells	4 years
E	/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):					
Е		_	Sequentially list conditions, b.	Due to (or as a conseque	nce of):					4
	led sit	oju e	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce or).					
	rificate be executed ng physicien and i as the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseque	nce of):					
68760	sicier buri									
9	entificate ling phy e as the	Medicai	· ·							
ŏ			IF FEMALE: 23b. Was decedent pregnant	sc. If yes, outcome of pregnand					23d. Date of del	very
1 00	death ce e attendii d for use	cla	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live birth 2 Fetal d 4 Pregnant at time of dea		Ectopic pregnancy Other (s <i>pecify)</i>			Month	Day Year
P.O.	t the by the	Physician/	9 □ Unknown	9□ Unknown						
	The law requires that the death ce ate has been signed by the attendi bage 2 should be detached for use	by P	Part II. Other significant conditions con	tributing to death but not result	ing in the ur	nderlying cause given in Pa	art I.	23e. Did tobacc	co use contribute to	the cause of death?
ğ	w require been signature	ed	Chr 180	1 reels				1 🖾 Yes	2 □ No 3 □ Pr	obabły 4 Dunknown
သူ	lawre as be 2 she	Completed						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
œ —	The ate h	шo.						performed 1 ☐ Yes 2 ☑	<pre>death?</pre>	2 No
Ħ	sian: artific ctor.	Be (25. Was case referred to medical examiner?			26. PI	lace of Death (C	Check only one)		
<u>></u>	Attending Physician: r death. sctor: After this certifica by the funeral director.	၉	1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐ EF					6 □Other (Spec	cify)
Ĕ	Ing P	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 2 (Month, Day Year)	8b. Time of Injury	Work?		I. Describe how in	njury occurred	
Sic	tend Jeath tor: /	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	On Diamentalian Alban		M 1 Yes 2		Location (Cture)		
Division of Vital Records,	or A after Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, iarm, stri	et, lactory, office	201	City or Town, Si	t and Number or Ru tate)	rai Houte Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Ü	29a. Certifier 12 Certifying Physics] Inten: Toithe best of my knowl	ados, doan	occurred at the time, date	and plans, and	dusto the cause	afel and parent se	stotat
	• Hor 24 h • Fur etely	edicai	(Check-only 2 Medical Examin	er: On the basis of examination and manner stated.	n and/or inv	restigation, in my opinion,	death occurred	at the time, date	and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License numb	oer	29d.	Date signed (Monti	n, Day, Year)
	0		I thank X 1	sun II		10151	46	11	127/166	
	1401		Name and address of person who con	npleted cause of death (Item 2	(Type,	Print)			1	
_	101.	11	Kichard A. Ba	im MiD.	1600	Crain Hu	y # 4	10 Gles	n Jurnie	21061
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signatur	e Am	12	1			
	Registi	ar	DEC 0 1 2006	18 105 15	STURE	-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38254 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 14.00 M JENNINGS 2006 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS BAYVIEW HEDICAL CENTER BALTIHORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1**∑**M 2□ F 228 10 6354 Director 87 VIRGINIA 01-14-1919 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location a or 28a-f show t be notified at 10a. State 10b. County 10d. Inside City Limits BALTIMORE MD ROSEDALE 1 ☐ Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1207 64TH ST. 21237 USA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: ₩₩II 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ð Specify: WHITE 3 Widowed 4 Divorced eted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Comple Elementary/Secondary (0-12) College (1-4or 5+) the ASSEMBLY LINE GENERAL MOTORS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL WILSON ပ DORTHA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINE WILSON/WIFE 1207 64TH ST., ROSEDALE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1
Department of Hi
Important: If iter
any injury or oth 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State GARDENS OF FAITH 12-02-2006 BALTIMORE, 4 Donation 5 ☐ Other (Specify) MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE., ROSEDALE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BACTEREHI **Physician** MRSA disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner SEPTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the bunal-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2**X**No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 Nation 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred eral Director; After filled in by the funera Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MBBS, DPhil RES001 Nou 29, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUSHIF WAOE, 4940 EASTERN AVENUE 10

Registrar
DHMH 17 Rev 1/2001

State

BACTIMORE

31. Date filed (Month, Day, Year)

DEC 0 1

2005

Registrar's Signature

Replacement

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			for State	State of Marylar		ent of Health and			20
			Registrar		Certifica	ate of Death		No. 2006	-38255
j.	Physic /Medi		1. December 1:5 Nylme (First, Middle, Last)	. Wade	2	1	2. Date of Death Month	& OC	3. Time of Death A
A.	Examii	ner	49 Facility Name (If not institution,) give to Color Wash	kuston Ce	dical soc	ty, Town, or Location of Dea	w a	Ac. County of Death	udello
F	Funeral Director		5. Social Security Number 6. Set 1 Security Number 6. Set 1 Usual Residence of Decedent	7. Age (In yrs.	Z Yrs. If Und Month	der 1 Year If Under 24 Hr. Is Days Hours Mir		1954 I Do	pplace (State or Foreign
	Maryland -f ehow	tor	10s. State Ot. County	undel 10c. Ci	ity. Town or Location	Burriol			10d. Inside City Limits
	death with the Maryland ms 23e or 28a-f show Lindel be notified at	Funeral Director	10a Stréet and Number	CU DI	10f.	Zip Code 2/060	10g.	Citizen of What Cou	
ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "netural", or Items 23e or 28e-f ehow any Injury or other traumatic event, the Medical Exertimetrical be rightlind at any Injury or other traumatic event, the Medical Exertimetrical be rightlind at another.	Funera	11. Marital Status Me Never Married 2 Married	12 Was Decedent Ever in U Amed Forces? 1 Yes 25 No If Yes, Give	If Yes, s	cedent of Hispanic Origin? () pecify Cubar, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White	
5-0036	72 hours after 'netural', or ite	Completed by	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade	Year or Dates:	16a. Decedent's U	sual Occupation work done during most of we	arkina 16b.	Specify . Kind of Business/li	ndustry
12121	filed within Hygiene. Ither then "	Compl	Elementary/Secondary (0-12)	College (1-for 5+)	GOCL O	Use Detired Urx	Ca	Sholu	Church
Maryland	iould be fi 1 Mental H narked ot natic ever	To Be	17. Father's Name (First, Middle, Last)	Jade		Nore	ma (First, Middle, Maid	ade	
_	l and 2 sho fealth and im 27 is ma her trauma	(194 Informant's Name/Relationship (Ty	Later (206. Print)	76281	ass (Street and Number or A	. Glers	urue, R	62/060
Baltimore,	permit. Pages 1 and i Department of Health Important: If Item 27 eny Injury or other tr once.		1 Surial 2 December 3 Reposition 2 Department 2 December 3 Reposition 2 Determined But 1 Department 1 Departm	emoval from State	Place of Disposition (A cemetery, crematory of	E remetery	Date 20c.	Location - City or T	re Ha
Bal	permit. Departimport eny Inj		21. Signature of Funeral Service License	Aden S	8. 1018	and Address of Facility	Ave Sa	thouse h	UNICES
-	Physician		23å. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	e cause on each line.	th. Do not enter the m ${\cal COPD}$	ode of dying, such as cardia	c or respiratory arrest,	/	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a consec					70-11-
	s be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	,				
68760,	- > w	cal	L	Due to (or as a conseq	uence or):				
.O. Box	The law requires thet the death certificate be evaite hes been signed by the attending physician bage 2 should be detached for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of degree Unknown	Il death 3 □Ectopic			23d. Date of deliv Month	ery Day Year
٥	uires thet signed b		Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tobacco	o use contribute to t	
Records,	he law requir e hes been s ige 2 should	Completed by	HTN				24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of
Vital	ysician: The lis certificate he director, page	0	25. Was case referred to medical			26 Place of Do	ath (Check only one)		2ENO
<u>></u>	Physician: this certifice ral director, p	ToB	examiner? 1 ☐ Yes 2 📉 0	ospital:	ER/Outpatient 3 1	Other	dome 5 Residence	6 Other (See	6.1
ion of			27. Manner of Death 27. Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how inj		<i>y</i> /
Division	al or Atter after dea I Director d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Street a City or Town, Sta	and Number or Rura te)	al Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifying Phys	ician: To the best of my kno ler: On the basis of examina and manner stated.	owledge, death occurre	nd at the time, date and place on, in my opinion, death occu	a, and due to the cause(urred at the time, date a	s) and manner as s nd place, and due to	stated. o the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	Messia	leus 2	9c. License number	29d. D	ate signed (Month,	Day, Year)
			30. Name and address of person who con	mpleted cause of death (Item	n 23a) (Type, Print)	& 4158 6 2 Suite 112,	Banamliz	MA 21	401
	Sta Registr		31. Date filed (Month Day, Year) DEC 1 3 200	3 Registrar's Signa	ture Angels		y-cop		

hysici	an	Decedent's Name (First, Middle, Last	")		in	11.			2. Date of De Month	Da	ay Yea	ar e	Time of De
/Medi	cal	Robert				llian			October		4- 200	6 18	:05
Examir	ner	4a. Facility Name (If not institution, give	street and number,	1 4		4b. City, To	own, or	Location of De	eath	40	c. County of D	eath	
ıneral		5. Social Security Number 6. Se			last birthday)	If Under 1	Year	If Under 24 H	Irs. 8. Date of Bir	rth	n/a	Pirtholace (State or F
rector		191-40-4941	M 2□F	55		Months	Days	Hours M	Sep. 2	Year	1951 PA	Birthplace (Country)	DIEIG OI I
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10 e	급	20220 Ravensdale	Crot			10f. Zip C				10g. C.	itizen of What	Country?	
na 2;	Funerai	11. Marital Status	12. Was Decedent	Ever in U	J.S. 13. W	298 as Decede		panic Origin?	(Specify Yes or No)-	USA 14. Race - A	merican Ind	lian.
el', or items 23a or 28a-f ehow Exeminer must be notified at		1 ☐ Never Married 2 ☐ Married	Armed Forces: 1 ☐ Yes 2 🔀	?	lf '	Yes, specify	/ Cuban	i, Mexican, Pu	erto Rican, etc.)		Black, W		,
급취	db	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		11	∐Yes 2∑	l No	Specify:	white		Specify:	hite	
"naturel", dical Exe	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)		16a. Decede (Give ki	nd of work	done di	tion uring most of v	vorking	16b. F	Kind of Busine	ss/Industry	
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ther.		17. Father's Name (First, Middle, Last)	4		Comput	er Pr			lame (First, Middle		ucation)	
O D O	To Be	Earl Williams							e Didion	, Maldel	i Sumame)		
7 is mari traumati	۲	19a. Informant's Name/Relationship (7)	/pe, Print)		19b. Mailing	Address (5	Street ar		Rural Route Numb	er City	or Town State	Zin Code)
27 is r trat		Carol L. Williams	- Wife		1				t. Montso			, ,,,	
Item 2 other		20a. Method of Disposition		20b.	Place of Disposit	tion (Name	of	arc or	Date		ocation - City		
nt:# ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		'	tro Crem				+ 16 06	· •	-1	10	-
Important: any Injury o once.		21. Signature of Funeral Service Licens	ee <i>1</i>		22.1	Name and	Address	of Facility	t. 16, 06				1
E = 8		11/a	CAROCA	9	2	99 Fr	ede:	Socie rick Ro	ty of Mar Dad Balti	y⊥ar more	id, Inc	1228	
		23a. Pag1. Enter the disease, or comp shock, or heart failure. List only o	lications that cause	d the dea	th. Do not enter	the mode of	of dying,	such as card	liac or respiratory a	rrest,			oximate al Betwe
physician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as				MEN!	APPROVE	O BY MEDICAL EXAMI	NER			
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should I	ete								-				
r, page 2 s	Completed								24a. Was autor perfo		death'	o completio	n of caus
is certific director,	o Be	25. Was case referred to medical examiner?	lospital:	05	1500		Other		eath Check only o	-			_
or this oral di	.T	27. Manner of Death	28a. Date of fnju (Month, Da		ER/Outpatient 28b. Time of		1	4 🗀 Nursing	Home 5 Resid			pecify)	
: Affe	₽ E	1	Unknown		Unknow		Injury a Work? 1 ☐ Ye	s 2X No	Probable				
To the Funeral Director: After this completely filled in by the funeral dir	Certification:	3 Suicide 6 Could not be determined		ury - At h	ome, farm, stree		ffice		28f. Location (S City or Tov	vn, State	nd Number or i	Rural Route	Number
etely fil	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best ner: On the basis o and manner st	r examina	owledge, death o ation and/or inves	ccurred at t stigation, in	he time my opia	, date and pla nion, death oc	ce, and due to the curred at the time,	cause(s)	and manner d place, and d	as stated. ue to the ca	use(s)
o the	Me	29b. Signature and title of certifier		<u> </u>		29c. L	icense i	number		29d. Da	te signed (Mo	nth Day Ye	ear)
- 0		1	ompleted cause of c			101	= 5	-00					
						No				UCTI	oner 1	116	
		30. Name and address of person who co	empleted cause of c	leath (Iter	m 23a) (Type Pri	int)							

			1 - For State Registrar	State of Ma	ryland			nt of H i <i>te of L</i>			lental H	ygien Reg. N		5	38257	
			1. Decedent's Name (First, Middle, Last)							2. Date of D Month		ay Y	'ear	3. Time of Death	_
-	Physici /Medic		ROBERT V	VARE							11			006	18:10 PM	
	Examin		4a. Facility Name (If not institution, give	6 1			i	y, Town, or		of Death			c. County of			
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de la	Funeral		5. Social Security Number 6. Se	Ом 2ПЕ		st birthday) Yrs.	Month	er 1 Year S Days	Hours	Min.	8. Date of B	ay, Yea	r)	Count	ace (State or Foreign Try)	1
***	Director		309-05-9726 Usual Residence of Decedent		93						sept	19,	1913 [лета	ware	-
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation							10	d. Inside City Limits	
	a-f s	io	MD Montgome	ry	Sil	ver S	orin	g							1 ☐ Yes 2 🛣 No	
	or 28	lre	10e. Street and Number				10f. 2	ip Code				10g. C	itizen of Wh	at Count	ry?	_
	ath w	rai	3128 Gracefield R					904					5.A.			
	perrait. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show amy njurry or other traumatic event. The Medical Exacting roual be notified at ADEC.	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N		. 13. \	Was Dec f Yes, sp	edent of Hi ecify Cuba	spanic C n, Mexica	origin? (Span) an, Puerto	ecify Yes or N Rican, etc.)	lo-	14. Race - Black,	America White, e		
21215-0036	urs aff	þ	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	0		1 🗆 Yes	2 ⊠ No	Specif	y:			Specify: V	√hit	2	
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Maryland	ntal H od ott	Be	17. Father's Name (First, Middle, Last) Harold Ware								(First, Middle Steph		n Sumame)			
Ž	hould Me	2	19a. Informant's Name/Relationship (7)	rpe. Print)		19b Mailin	na Addre	ss (Street a			Al Route Num		or Town St	ate Zin	Code)	_
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Ë	Page ient o int: If ry or		1 ☐ Burial 2 🗓 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	1	•	-		,	Nov	29, 06	Od	enton,	Ma	ryland	
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Physicia	an/	Registrar 1. Decedent's Nam	ne (First, Midd	le,Last)			_				2. Date of	Death		3. Time of Death
dical Exami		Steffre	n DeKo	ven V	Wilson_							ber 24,	2006 Year	2345 hrs
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Funeral Director					ľ			Mont			Min.		Foreig	gn Michigan
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ospi hou mer y fil		4 Homicide	1	ermined	(Specify) Loc						,			on Street, Frederick,
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To the within. To the comple	Med	29b. Signature and	d title of certific	er er	d manner stated	>		led?	-	se number			Date signed (Mo.	
			111		DAC				O.C.	M.E.			vember 25, 20	

30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State Registrar DEC 0.1

32, Registrar's Signature ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. anend item 5 per in 967 5-3-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Emma L. Wetzel 5:30AM November 30 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner harlestown Year | If Under 24 Hrs. e TIMOre 5. Social Security Number 74 If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 183 - 12 - 71711 ☐ M 2 ☐ XF 85 Vre **Director** 6-15-1921 PΑ Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County •how r then "natural", or items 23s or 28s-f ehov the Madical Exeminer must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 701 Maiden Choice Lane 21228 USA death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status should be filed within 72 hours after and Mental Hygiene.
marked other then "natural", or Item 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White \$ Specify: 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Heelth and Mental P int: if item 27 ie marked of Joseph Earl Snyder Helen Wahrmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Schmalbach - Daughter 506 Summerbreeze Dr., Newark, DE 19702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) important: if Bayview Crematory 12-1-06 Baltimore, MD permit. Departn 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bradley-Ashton Funeral Home eny ir PA, 2134 Willow Spring Road, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atherosclerotic Vascular Disease **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner attending physicien and for use as the burial-transit the Hospital or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ 100 the detached 9 Unknown 9 Unknown Š been signed t should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 3 Probably 4 Junknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? certificate 1 ☐ Yes 2 1NO 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☐ Hor 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funarel Direct 1 chrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature at 2 D47009 November 30, 2006 on who completed cause of death (Item 23a) (Type, Print) 30. Name and addr Maiden Choice Lane, Baltimore, MD 21228 10

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32 Registrar's Signature

06-08827 Jacqueline Agnant

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certifica		Re	g. No.	100 3020			
Physicia Vledical Exami	4117	1. Decedent's Name (First, Middle, Jacqueline Mari	·					2. Date of Deat Month November	Day Year	3. Time of Death 1958 hrs	
	ı	4a. Facility Name (if not institution, Laurel Regional Hospita	-		41	c. City, Town, or Lo Laurel	ocation of Death		4c. County o		
Funeral Director		054-44-3424	. Sex 7. Age (In	yrs. last birt	hday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Bir	`	9. Birthplace (State or Foreign Country) Haiti	
Varyland 28a-f show any <u>1 at once.</u>		Usual Residence of Decedent 10a. State Maryland Prince		. City, Town Laurel		n				10d. Inside City Limits 1 XYes 2 No	
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 8301 Ashford Blv	<i>r</i> d.,#813			10f. Zip Code 20707		11	og Citizen of Whail	-	
15-0036 filed within 72 hours after death with the Maryland Hygiene. ed other than "natural", or items 23a or 28a-f sh. t, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divord 15. Decedent's Education (Specification (Specification)	1 Yes 2 1 ced If Yes, Give Year or Dates:	No	If Ye	Decedent of Hisps s, specify Cuban, I Yes 2 No s Usual Occupatio	Mexican, Puerto R	tican, etc.)	14. Race White, Specify:	Black	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First, Middle, La Lys Dimanche				I	rancois	e Locha			
MD 2' nd 2 should lith and Me m 27 is ma	٥	19a. Informant's Name/Relationship Lucien P. Agnant	-son	83	801 As	shford Bl	Lvd.,#813	3 Laure	1, Maryl	s, State, Zip Code) Land 20707	
Limore, Pages I an tment of Hea tant: If itee	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location										
Si Si	1	Ke K. J	l Home, sville,	PA Maryland20705							
Physician /Medical īxaminer		23a Part I. Enter the disease, or confailure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	est, snock, or nea	rt Approximate Interval Between Onset and Death							
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown	23c. If yes, outcome of Live birth 4 Pregnant at time 9 Unknown	2		al death 3 er (Specify)	Ectopic pregnan	су	23d. Date of o	delivery Day Year	
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Division of To the Hospital or Attending Phavitin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical C	one) 2 Medical Exami	sician: To the best of my kn iner:On the basis of examina and manner stated.	-		on, in my opinion, o	death occurred at				
	ž	29b. Signature and title of certifier				29c. License O.C.M			29d. Date signe	d (Month, Day, Year) 20, 2006	
•		30. Name and address of person was Ana Rubio MD. Assis	the completed cause of death		Penn St	reet, Baltimor	e, MD 21201				
St Regis	tate trar	31. Date filed (Month, Day, Year)									

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	sicia	n	Registrar Decedent's Name (First, Middle, Last DOROTHY ANN	,		- 001	imodio or i		2. Date of De Month November	Day	0 0 jo	3 Time of Dec	5 M
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uld be filed Mental Hyg Irked other	nic event, i	To Be Co	17. Father's Name (First, Middle, Last) Frederick		n			18. Mother's N	Name (First, Middle n McGui		name)		
and 2 sho ealth and 1 m 27 is ma	ner trauma		19a. Informant's Name/Relationship (Marilyn J. Hodge,			8904	A Indian		Rural Route Numb	Freder	ick, M	D 21702	
Page nent c	ijury or on		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	v)	CA	 Johr 		ery Nov	7. 28, 20	06 Fre	on - City or T ederic		
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The law re	page z sno	Completed	ALGAI	Fibrill	ako	n			24a. Was auto perf 1 Yes		lb. Were aut prior to co death? 1 ☐ Yes	opsy findings ava ompletion of caus	lable a of
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Hospital or 4 hours after Funeral Di	rery filled in	edical Cer	29a. Certifier (Check only one) Certifying Pr 2 Medical Exar	ysician: To the best	of my know f examinati	/ledge, deat	n occurred at the ti	me, date and pl	ace, and due to the	e cause(s) and	manner as	stated. to the cause(s)	
To the within 2	eidinoo	Med	29b. Signature and title of certifier	and manner st			29c. Licens	C		29d. Date sig	1. "		
T ₁	F		30. Name and address of person who Hemen Shah 31. Date filed (Month, Day, Year)	completed cause of d	eath (Item	23a) (Type,	Print) nsan I	or Fr	ederick	, MI	217	162	
	Sta gistr	ar	31. Date filed (Month, Day, Year) NOV 3 0 2	32. Registr	ar's Signati	ure	ale						
DHMH 17 Re	ev 1/20	01				-							

State of Maryland / Department of Health and Mental Hygiene 38262 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Rudolph Nelson Birney, Sr. Verlinber 22 /Medical 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 399 Leeds Road E1kton Ceci1 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NOV 18, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Director Yrs 222-16-0101 18, 1927 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23s or 28s-f show eny injury or other traumatic event, the Mudical Examinar must be married and 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Ceci1 Mary1and E1kton 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 399 Leeds Road 21921 Completed by Funeral United States 12. Was Decedent Ever in U.S. Amed Forces? 1 M Yes 2 □ No 1945-If Yes, Give Year or Dates: 1952 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Automobile Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 11 Stock Chaser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles C. Birney ٩ Phoebe M. Hollett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda S. Birney/Wife 399 Leeds Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of Cherry Hill Methodist Cemetery 20a. Method of Disposition November 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 28, 2006 Cherry Hill, Maryland Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** 1ears /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the ca Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Medical Certification: To Be Completed by 1 Yes 2 □ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 210 No 1 ☐ Yes 2 ☐ No 1 Yes : After this certifical tuneral director, r 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funaral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Sutcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Fo the 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sasons Hos 32/Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 3 0 2006 Registrar

			1 - For Stete Registrar	State of Maryland	d / Depa <i>Cer</i> t	rtment of I	Health and <i>Death</i>		giene () () ()	38263
	Physici	an	1. Decedent's Name (First, Middle, Last)	THUR BA	ARI			2. Date of De.		3. Time of Death $10:18A^{M}$
	/Medio Examir		4a. Facility Name (If not institution, give s	treet and number)		*	or Location of Dea		4c. County of Deat	h
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	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits
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	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or items 23a or 28e-f show aumatic event, the Medical Examiner matternellised at	Funeral Director	10e. Street and Number 9701 – Veir	s Drive		10f. Zip Code	20850		10g. Citizen of What Co	untry?
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36	rs after I', or Ita	oy Fu	1 ☐ Never Married 2 ☐ Married 3. Widowed 4 ☐ Divorced	1X Yes 2 No If Yes, Give Year or Dates WW 1	1	☐ Yes 21 No		110 1110411, 510.7		nita
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	1 and 2 sho Health and tem 27 le mu		19a.Informant's Name/Relationship <i>(Typ</i> Martha Bari- Dau						er, City or Town, State, Z Silver Spi	
3altimore,	S to II		20a. Method of Disposition 1 🗆 Burial 2 📉 Cremation 3 🗆 Re	C6	ace of Disposi	atory or other pla	ce)	Date 7	20c. Location - City or T	
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of	ding Phye	n: To	27. Manner of Death	1 Inpatient 2 E	28b. Time of Injury	3 DOA 28c. Inju	ry at		lence 6 Other (Spec low injury occurred	ify)
Division	Attending or death. rector: After by the funer	catio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1	Yes 2 □No			
DIVI		Certification;	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stree	et, factory, office		28f. Location (S City or Tow	Street and Number or Rui m, State)	al Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical C	29a. Certifier 1 Certifying Phys (Check only one)	icien: To the best of my know er: On the basis of examinati	vledge, death of	occurred at the ti	me, date and place	e, and due to the curred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.	1	29c. Licens	se number		29d. Date signed (Month)	Day, Year)
	7		Male	W. Kares	hu	1) 1) 0	21726	5 /	lovember	15,2006
R	(8)		30. Name and address of person who con DR • CHARLES				S DRIVE	, ROCKV	/ILLE,MD.	
*	Sta Registr		31. Date filed (XXXXIII) Day. Year 1006	32. Registrar's Signat	Source .	,				

DHMH 17 Rev 1/2001

38264

			1 - For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of He rtificate of L		, ,	ene 1. No.	
	Physic		Decedent's Name (First, Middle, L Alice	Ann	Bou	rdeau		2. Date of Death Month November		3. Time of Death 7:45 A M
	/Medi Examii		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 6. 014-28-7418		69 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, Y	O. Bish	place (State or Foreign ntry), achusetts
	Aaryland I show	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Frederi	ck	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🜁 No
	or 28e-	Director	10e. Street and Number	<u> </u>		10f. Zip Code		10g	. Citizen of What Cou	
	eth wi		5738 Little Sprin	-		2170)4		USA	
9800	be filed within 72 hours after deeth with the Maryland lat Hygiene. d other than "naturel", or items 23a or 28e-f show event, the Medical Examinat must be routiled at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 It If Yes, Give Year or Dates:	No	Was Decedent of His If Yes, sp <i>ec</i> ify Cuban 1 ☐ Yes 2 ∑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh:	etc.
21215-0036	within 72 h ene. than "natu he Medicel	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	(Give life.	dent's Usual Occupation of work done du DO NOT use retired)	iring most of work	ing	b. Kind of Business/In	
	filed y Hygie other i		17. Father's Name (First, Middle, Las	1)	Cust	tomer Serv		e (First, Middle, Ma	Manufactu:	ring
/lan		To Be	J. Edwa	rd L	ausier		Ann		Ruest	
Maryland	12 sh h and 7 ie m		19a. Informant's Name/Relationship Leo J. Bourdeau/H		19b. Mailir 5738	ng Address (Street ar Little Sp	orings Wa	al Route Number, C	City or Town, State, Zip	Code) 1704
Baltimore,	of H		20a. Method of Disposition 1		20b. Place of Dispo cemetery, crer	natory or other place)		c. Location - City or To	
Baltir	permit Page Department of Important: if any injury or		21. Signature of Finery Service Lice		22	. Name and Address	of Facility Sta	uffer Fur	neral Home lerick, MD	, PA
68760,	Physician by hysician and physician and physician and streams the purial-transit	sal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as	a consequence of): a consequence of):	lung	a den	ocarcin	0 m 01	Onset and Death Month
P.O. Box 68	death certii e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive	ory Day Year
	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the ur	nderlying cause given	in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
örd	w require been sig should b	ted	Diabetes	necut	7			1 🗆 Yes	2 No 3 □ Prob	ably 4 □Unknown
al Reco	: The law r cate has be page 2 sh	Completed	Hyportentic	M				24a. Was an autopsy performed	prior to cor death?	psy findings available inpletion of cause of
Ĭ,	Bician certifi rector	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:				(Check only one)		
ō	g Phy er this eral di	n: To	27. Manner of Death	28a. Date of Inju		28c. Injury a	it " ;	me 5 Residence 28d. Describe how i	e 6 Other (Specify)
Division of Vital Records,	or Attending Physician: siter death. Director: Atter this certifica in by the funeral director, is	Certification;	Natural 5 Pending investigatio 3 Suicide 6 Could not be determined	e 000 Diago of lai	ury - At home, farm, stre	M 1 □ Ye	es 2 🗆 No		t and Number or Flura	l Route Number,
<u> </u>	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai Ce	29a. Certifier Check only one) Certifying Pr	ysician: To the best on the basis of and manner sta	of my knowledge, death examination and/or invited.	occurred at the time estigation, in my opir	, date and place, a	and due to the cause	(c) and manner as at	ated. the cause(s)
)	To th Withir To th comp	Me	29b. Signature and title of certifier	iren 1	Shah	29c. License r	<i>a</i>	29d.	Date signed (Month, I	Day, Year)
,	C		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, I	Print)	- 4 - 1	1	17 0	
	Sta	te	31. Date filed (Month, Day, Year)	2006 32. Fagistia	n's Signature	made 1	reven	MS MY	1 21702	M

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 1305 2004 Bruce, Sr /Medical Charles 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Nicomico SALISHIC REGIONA Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Min 1 MM 2 □ F Months Days Hours **Director** 04 - 05 - 1927New Jersey Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Somerset Princess Anne 10e. Street and Number 10g. Citizen of What Country? 12875 Backbone_Road **USA** 21853 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify. þ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer <u>Agriculture</u> none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marshall Hughes Bruce Marie Ross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Coven/Niece 7 Village Way, Smithtown, New York 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 11/22/2006 Beechwood Cemetery Princess Anne, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ir mediate Cause (Final sease or condition resulting in death) Bladdercancer **Physician** 6 Monday /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 ☐ Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy this certificate 1□ Yes 2 1 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA P 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Non 2rle Do 57359 DR. USHA NATESAN November 21st 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY . S. DIVISIONS 32. Regintrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 2 2 2006

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of H	lealth and <i>Death</i>		giene () Reg. No.	06	3826	6
	Physici	an	1. Decedent's Name (First, Middle, L	,	_			2. Date of De Month	Day	Year	3. Time of Death	
	/Medio		PAUL RAYMONI						14 20		5:34 A	М
	Examir	er	4a. Facility Name (If not institution, g		7)		r Location of Dea	th		y of Death		
			744 MURPHY ROAI 5. Social Security Number 6.		ge (In yrs. last birthday		EVILLE	s. 8. Date of Bir		EN ANN		. :
	Funeral Director		218-58-0526	1 X M 2□F	54 Yrs.	Months Days	Hours Min	. (Month, Da	y, Year)	Court		эgп
			Usual Residence of Decedent		<u> </u>			DEC. 4	1901	MAKI	LAND	
	ehow	_	10a. State 10b. County		10c. City, Town or L	ocation				1	Od. Inside City Lim	
	8a-1	Director	MD QUEEN	ANNE	CENTR	EVILLE					1 ☐ Yes 2 🗶 1	No
	ith th	Pi-	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?	
	e 23e	rai	744 MURPHY ROAI		5 :: 110	2161			USA			
	Iten de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceden Armed Forces 1 Yes 2	?	Was Decedent of H If Yes, specify Cubi	an, Mexican, Pue	specify Yes or No rto Rican, etc.)		ce - Americ ack, White,		
ဗ္ဗ	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "netural", or Iteme 23a or 28a-f ehow other, the Madical Examinal must be neillied at	<u>م</u>	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates		1 ☐ Yes 2 📉 No	Specify:		Speci	ty: WH	ITE	
Ö	2 ho	Completed	15. Decedent's	Education	16a. Dece	dent's Usual Occup	pation	4.:	16b. Kind of 8	Business/Inc	lustry	-
2	en "n	pie	(Specify only highest g	College (1-4or	life.	kind of work done DO NOT use retired	auring most of wo d)	orking				
7	filed wi Hygien other th	် ပ	12	-0-		MECHANIC				DMOBIL	E	
Ē	tal H d out	Be	17. Father's Name (First, Middle, Las					me (First, Middle,		,		
<u>\S</u>	2 should be filed a and Mental Hygie is marked other i eumatic event, the	၉	EARL RAYMOND	BRADLEY			MARY					
Ž	and 2 st ath and 127 is n er treun		19a. Informant's Name/Relationship JAMIE BRADLEY/ S			ing Address (Street PRICE ST			-			
altimore,	Pages 1 anent of He Int: If Item Iny or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec			osition (Name of matory or other place MEMORTAL		Date -17-2006	20c. Location	- City or To		
Baltir	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke ery injury or other treumatic. once.		21. Signature of Funeral Service Lice		F	2. Name and Addre	LFENBEIN	V & NEWNA	M FUNEI	RAL HO	ME. P.A.	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	4 d the death. Do not en	08 S. LIB	ERTY ST.	CENTRE	VILLE.	MD 21	Approximate Interval Between	
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a	relacta	tu.	Cone	e,			Onset and Death	
	Examiner			Due to (or a	s a consequence of): Entire	a)	Cone					
	led Isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):							
o,	ate be executed hysician and the burial-transit	Examine	that initiated events resulting in death) Last	Due to (or a	s a consequence of):							
09/89	the the	dical		d								
Box	leath certific attending p	N/S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom-					23d. Da	ate of delive	rv	
_•	0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No			□Ectopic pregnancy □ Other (specify)					Day Year	
7	that the de led by the detached		9 ☐ Unknown Part II. Other significant conditions		but not reculting is the	undorking on uno au	an in Bad I	220 Did to		tabuta ta th	e cause of death?	
ecords,	law requires that the as been signed by th 2 should be detache	ed by	Tarrii. Ottor algimeani contracti	continuating to death	but not resulting in the t	miderlying cause giv	en in Part I.		es 2 No		ably 4 Unknov	
၀ ၀	awre	piet						24a. Was		Were autop	sy findings availat	ble
	e 4 8	Completed						autop perfor 1 Tyes	rmed?	death?	npletion of cause o 2 □ No	H
	icien: T certificat rector, pa	BeC	25. Was case referred to medical examiner?				26. Place of De	ath Check only o				
	dis y	10 E	1 Yes 2 No	Hospital: 1 ☐ Inpat	ient 2 ER/Outpatie	nt 3 DOA Oth	er: 4 ☐ Nursing I	Home 5 Resid	lence 6 □Ott	ner (Specify)	
	ding After fune		27. Manner death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Inj (Month, D	ury 28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	now injury occur	rred		
DIVISION	or Attendentifier deat Director: in by the	ertification:	3 Suicide 6 Could not 4 Homicide determine	d 28e. Place of in	njury - At home, farm, st	reet, factory, office		28f. Location (S City or Tox	Street and Num vn, State)	ber or Rural	Route Number,	
	pital ours a eral I	O	29a. Certifier 1 ☐ Certifying F	Physician: To the best	t of my knowledge, deat of examination and/or in	h occurred at the tin	ne, date and place	e, and due to the	cause(s) and m	anner as sta	ated.	- 33
	To the Hos within 24 ho To the Fun completely	Medicai	One/	and manner s	tated.							
ı	S T K	-	29b. Signature and title of certifier	-//		29c. Licens	127.	0	29d. Date signe			
			on the	Nan	4		5 5 5 6	0	1//14	106	>	
			30. Name and address of person who	completed cause of	death (Item 23a) (Type,	esta ate	Pla	to 300	Whin	4/2/	214 15 m)	0,
100	Sta	te	31. Date filed (Month, Day Year)	32. #agist	rar's Signature	- 212996	~ >	,00	NAME OF THE PERSON OF THE PERS	-1/- 1	() m!)	
	Registr		NOV 16	2006	w & A	redu						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 38267 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10:40 PM CHARLES REX BLY NOVEMBER 14 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STEVENSVILLE 21666 120 LONG POINT RD. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 ☐ F Director ILLINOIS 361-03-1757 85 08/04/1921 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location nd 2 should be filed within 72 hours after death with the Marylan thin and Mental Hyglene. 27 is marked other than "natural", or itema 23a or 28a-f ahow treumatic avent, the Modicel Examina must be notified at 10a State 10b. County 1 ☐ Yes 2 No Director QUEEN ANNE'S **STEVENSVILLE** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 LONG POINT RD. 21666 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1942–46 1 Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 BOILER OPERATOR FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any Injury or other traumatic av once. ٩ JOHN BLY LELA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6504 WILSON RD., FRIENDSHIP, MD JOHN CHARLES BLY / SON 20758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESTHAVEN MEM. GARDENS 11/18/2006 FREDERICK, MD 21. Signature of Fungral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACU Abdom WAL Physician /Medical month (Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examine physicien and s the burial-transit death certificate be executed Due to (or as a consequence of): of Vital Records, P.O. Box 68760. Physician/Medical use as t ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 20 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate 1 Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only 6ne) Hospital: 1 Inpatient Other: 4 Nursing Home 1 Yes 2 ဥ No 2 ER/Outpatient Residence 6 Other (Specify) 3 DOA 5 this 28a. Date of Injury (Month, Day Year) After thi 27. Manger of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural
2 Accident 5 Pending 1 Tyes 2 □No death. investigation Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai (Check only one) 29b. Signature and Nie of certifier 29d. Date signed (Month, Day, Year) 29c. License number e and address of person who completed cause of death (Item 23a) (Type, Print) PATRICIABO WY MO, MPH 130 Love Point ROAD STEVENSULL

32. Begistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 16 2006

		ŀ	1 - For State Registrar	State of Ma	ryland /		artmen rtificate				iene g. No.	106	38268
	Physici		1. Decedent's Name (First, Middle, Las Madeline Mary Bi	,						2. Date of Dea Month Novemb	Day	Year 2006	3. Time of Death 5:30 P
	/Medi Examir		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of Deal		1	y of Death	1 5:30 P
			Berlin Nursing &	Rehabilit	ation		Be:	rlin			Worce	ester	
	Funeral Director		5. Social Security Number 6. S 198-07-5967	ex	(In yrs. last	birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min.	(Month, Day	Year)	9. Birthpl Coun PA	ace (State or Foreign try)
	p ,		Usual Residence of Decedent		10- Cit. T								
	shove	5	10a. State 10b. County		10c. City, To		ication					10	0d. Inside City Limits 1 Yes 2 No
	the M	Director	MD Worceste 10e. Street and Number	er	Ber1	ın	10f. Zip	Code		1	0g. Citizen of	What Cour	
	3a or		9715 Healthway Di				218			'	USA	What Court	uy:
	death	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13.			spanic Origin? (S	specify Yes or No- to Rican, etc.)	14. Ra	ce - America	
36	or ite	Fu	1 Never Married 2 Married	1 ☐ Yes 2√13 No	0		1 ⊡ Yes 2		Specify:	to rilcan, etc.)		ick, White, 6 fy: Whit	
ğ	within 72 hours atter death with the Maryland ene. then "naturat", or items 23a or 28a-1 show ha Medical Examinar must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1 2								
5	in 72 n nat	Completed	15. Decedent's Ec (Specify only highest gra	de completed)		(Give	dent's Usua kind of wor DO NOT us	k done d	uring most of wo	rking	16b. Kind of E	Business/Ind	lustry
212	y withir piene. r then	mo	Elementary/Secondary (0-12)	College (1-4or 5-	+) I		ing Te				Dance	e Stud	lio
nd	al Hygie other ont, E	BeC	17. Father's Name (First, Middle, Last)						18. Mother's Na	me (First, Middle, I	Maiden Suma	me)	
<u>y</u>	2 should be and Mental I is marked or reumatic eve	10	John Joseph Brad	ly					Cathe	rine Fla	ve11		
Baftirfore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours atler death with the Marylan I Health and Mental Hygiene. Item 27 is marked other then "naturat", or items 23e or 28e-1 show tiem 27 is marked other then "naturat", or items 23e or 28e-1 show other treumatic event, the Medical Examinar must be notified at	0.3	19a. Informant's Name/Relationship (** *	1					ıral Route Number	-		Code)
√	Health tem 27 other tr		20a. Method of Disposition	(11200)	20b. Place					, Berlin	9 MD Z		wn, State
E C	permit. Pages Department of H importent: If ite any injury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		1					0/2006			
a	permit. Departmimporter any inju		21. Signature of Funeral Service Licen		, nor	22	. Name and	d Addres	s of Facility Th	e Burbage	Funer	а1 Но	me
<u>m</u>	P P E E		N. Kup /2	untale									
Physician / Medical Examiner Physician / Medical Examiner Sequentially list conditions, if any, leading to immediate a consequence of the control of the c													Approximate Interval Between Onset and Death
8760,	death certificate be executed. e attending physician and of for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a					7, 10				
P.O. Box 68	that the death certitics ed by the attending pt detached for use as ti	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1	2 ☐ Fetal dea		Ectopic pre				2.0	ate of deliver	y Day Year
	law requires that as been signed E 2 should be deta	by	Part II. Other significant conditions of	Ontributing to death but	t not resulting	g in the ur	nderlying ca	ause give	n in Part I.		acco use con		cause of death?
Vital Records,	The ate h page	Completed								24a. Was ar autops perform 1 Yes 2	red?	prior to com death?	sy findings available upletion of cause of
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	c 4	th (Check only one			
Division of	Jing After fune	tion: To	1 Yes 25 No 27. Manner of Death 1 A Natural 5 Pending investigation	28a. Date of Injury (Month, Day	285	Outpatien Time of Injury		Bc. Injury Work		ome 5 Reside 28d. Describe ho)
Divisi	To the Hospitet or Attending Ph within 24 hours after death. To the Funerel Director: After th completely tilled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, (Specify)	farm, stre	et, factory,			28f. Location (Str City or Town		oer or Rural	Route Number,
	To the Hospitet or within 24 hours after To the Funerel Dir completely tilled in	edical	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of tiner: On the basis of a and manner state	examination :	lge, death and/or inv	occurred a restigation,	at the time in my opi	e, date and place inion, death occu	, and due to the ca rred at the time, da	use(s) and mate and place,	anner as sta and due to	ited. the cause(s)
	To t withi To tl	Σ	29b. Signature and title of certifier	, ,	-	~	29c.	License	number	29	d. Date signe	d (Month, D	ay, Year)
•			1/1/060	win	- 0	كك	E) 7	1876	9 1	11/1	= 10	6
_	3A 6		30 Same and address of person who of the Constant Box	deling in	9 1:	а) (Туре, Ze)	. //	cha	1 Hat	Levey Th	eculel	t Isla	Ll, Delgaux
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 6 2		r's Signature	A	book	,	3	()			/

DHMH 17 Rev 1/2001

			1 - For State Registrar	tate of Maryland		artment of H			ene g. No. 200	5 38269
	Physici	an	1. Decedent's Name (First, Middle, Last) John A. Becker					2. Date of Death Month	Day Yea	
1	/Medic Examin		4a. Facility Name (If not institution, give stree The Arbor at Bay Woo			4b. City, Town, or Ann	Location of Deat	Novembe	4c. County of De	10:49
	Funeral Director		5. Social Security Number 468–16–6871 6. Sex 1120 M Usuel Residence of Decedent	2□ F 7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day,		irthplace (State or Foreign Country) Indiana
	Maryland a-f ehow	tor	10a. State 10b. County Maryland Anne Arund		Town or Lo		napolis			t 0d. Inside City Limits 1 ☐ Yes 2√€ No
	3a or 28	i Direc	10e. Street and Number 7101 Bay Front Driv	re, #311		10f. Zip Code	21403	10	g. Citizen of What (•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f ehow early injury or other treumatic event, Ita Modical Examinat must be notified at ODGE.	by Funeral Director	1 ☐ Never Married 2€ Married	Nas Decedent Ever in U.S. Armed Forces? Takes 2 \(\) No f Yes, Give Year or Dates: 1944-		Vas Decedent of His f Yes, specify Cubar ☐ Yes 2☐¶No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - An Black, W! Specify:	
21215-0036	d within 72 ho giene. or then "natur it e Madicel.	Completed	15. Decedent's Educatic (Specify only highest grade co Elementary/Secondary (0-12)		(Give life. L	lent's Usual Occupa kind of work done d DO NOT use retired) trical End	uring most of wo	orking	6b. Kind of Busines Westingl	
Maryland	ould be fite Mental Hy arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) John Joseph Becker					_{me (First, Middle, M} Lyn Patter		
	and 2 sho salth and n 27 is my		19a. Informant's Name/Relationship (Type, Caroline June Becke	r/wife	7101 1	Bay Front		#311, Ann		
Baltimore,	Pages 1 nent of He ant: If Iten ury or oth		20a. Method of Disposition 1523 Burial 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	oval from State	etery, cren land V	sition (Name of natory or other place Vets Ceme	tery 11,	/15/2006 C	c. Location - City of	le, Maryland
Balt	permit. Departifimporti		21. Signatur Fameral Servide Licensee	tille				ohn M. Tay ester St.,		cal Home Ls, MD 21401
,	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one or immediate Cause (Final disease or condition resulting in death) Sous fish, list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Poly Modern Poly M	1/q nce of): 1ers			c or respiratory arres	st.	Approximate Interval Between Onset and Death day
8760,	tificate be executed og physician and as the burial-transit	Icai	that initiated events resulting in death) Last	Due to (or as a consequen	nce of):					
.O. Box 68	death cer e attendir ed for use	Physician/Med	in the past 12 months?	f yes, outcome of pregnanc 1□Live birth 2□Fetal de 4□Pregnant at time of deat 9□Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
rds, P.	sign sign d be	þ	Part II. Other significant conditions contribu	uting to death but not resulti	ng in the ur	nderlying cause give	n in Part I.	23e. Did toba	N./	to the cause of death? Probably 4 □Unknown
Vital Record	ysician: The law requisis certificate has been director, page 2 should	Completed						24a. Was an autopsy performs	prior to	autopsy findings available completion of cause of second No.
Vita	Physician: this certificatal director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ital: 1 ☐ Inpatient 2 ☐ EF	VOutpatient	t 3□ DOA Othe		ath Check only one	ce 6 □Other /So	acifu)
ion of	ding Pt After th funeral	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		3b. Time of Injury	28c. Injury Work		28d. Describe how		oony
Division	P tage	Certification:	3 Suicide 6 Could not be 4 Homicide determined 2	 Place of Injury - At home building, etc. (Specify) 	e, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funsral Completely filled	ledical	(Check only 2 Medical Examiner:	n: To the best of my knowle On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time estigation, in my op	e, date and place inion, death occu	e, and due to the cau urred at the time, date	se(s) and manner a e and place, and du	as stated. ue to the cause(s)
)	To with	Σ	29b. Signature and title of certifier	mo		29c. License) 0295	7/	1. Date signed (Mor	2006 2006 MD 21114
			30. Name and address of person who complete PQUIBERS	MD 222	5E	Defen	al the	y, Cro	fton,	MD 21114
	Sta Registr		31. Date filed (Month, Day, YNO V 1 4	2000 Signatur	· K	Sperk	,	/ /		-

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** AM ELMER DANIEL BREEDEN NOVEMBER 11 2006 7:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 905 MONROE MANOR RD. ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months 78 Director 03/08/1928 228-30-4023 D.C. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 10d. Inside City Limits 1 Tyes 2X No MD QUEEN ANNES STEVENSVILLE Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 905 MONROE MANOR RD. 21666 USA 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) MASTER PLUMBER/BUSINESS OWNER PLUMBING & HEATING 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be finand Mental H permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked 4 eny july or other treumatic ever spice. BENJAMIN BREEDEN ETHEL BURKE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUNE BREEDEN / SPOUSE 905 MONROE MANOR RD., STEVENSVILLE, MD 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION | 11/13/2006 | STEVENSVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK RD., CHESTER, MD 21619 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cander LUNS 6Manths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a our sequence off law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' certificate 1 Yes 2 No 1 Yes 2 No director Be 25. Was case referred to medical 26. Place of Death | Check only one examiner Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending death, 2 Accident investigation 1 Tyes 2 No Director; / 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide thin 24 hours at the Funerei D 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 00064379 13/ مان 30. Name and addr ss of perion who completed cause of death (Item 23a) (Type, Print) Annupolis UD 21401 Restaple Rd. MIT Registrar Signature T 5 2006 State Registrar

DHMH 17 Rev 1/2001

State Registrar

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perter

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Signature

Kuggin bothan

31. Date filed (Month, Day, Year)

D 55 994

Canpus Rd

Funeral

Baltimore, Maryland 21215-0020 Elementary/Secondary (0-12) College (1-4or 5+) Teacher/Administrator permit. Pages 1 and 2 should be filed be partment of Health and Mental Hygin Important: if item 27 is marked other 17. Father's Name (First, Middle, Last) Be ဥ George Nelson Archibald 19a. Informant's Name/Relationship (Type, Print) Mabel J. Cassidy/Self 20a. Method of Disposition Nov. 21. 1 \$\overline{\mathbb{M}}\$ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Immaculate Conception Cemetery 2006 21. Signature of Funeral Service Licensee **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical Due to (or as a consequence of) attending for use as signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was cas examine . Hospital: 1 Ye 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28b. Time of unknjury 1 □Natural 5 Pending investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide rome 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 025915 NO 30. Name and address of person

Amend #28a-b, perME, g862,12/16/06 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Mabel Jeannette Cassidy November 16, 2006 1044 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Elkton Ceci1 5. Social Security Number If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 💢 F Yrs. 218-46-1650 Massachusetts Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Maryland Ceci1 Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 Maffitt Street 21921 Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21☑ No þ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Education 18. Mother's Name (First, Middle, Maiden Surname) Annie Elizabeth McDermott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Maffitt Street, Elkton, Maryland 21921 20c. Location - City or Town, State Cherry Hill, Maryland Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 112 Maffit Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ed cause of death/(Item 23a) (Type, Print) Suile 214 ElKton

State Registrar

			1 - For Stata Registrar	State of M	laryland / De	oartmen e <i>rtificat</i>			and M	lental Hy	giene 0	06	38273
100	Physic /Medi			V.	Cline					2. Date of De Nov 25	, 2006	Year	3. Time of Death 7:30 am ^M
	Exami	ner	Aa. Facility Name (If not institution, git Cumberland Cou S. Social Security Number 6.	ntry House) ge (In yrs. last birthda	Cun	nber	Location of land			Alleg		
- 4	Funeral Director			1 M 2 XF	87 Yrs.	Months	Days	Hours	Min.	8. Date of Bir Month Da Jul 15	1919	9. Birth	place (State or Foreign
	e Marylan e-f show	ctor	MD 10a. State Allega	iny	10c. City, Town or Cun	Location iberlar	ıd					1	0d. Inside City Limits 1 □Xes 2 □ No
	ath with th	Funeral Director	10e. Street and Number 117 Humbird Street	et		10f. Zip		21502)		10g. Citizen o	What Cour	ntry?
9600	tiges 1 and 2 should be tiled within 72 hours atter death with the Maryland nt of Health and Mental Hyglene. If Item 27 is marked other than "neturel", or Items 23a or 28a-f show or other traumatic event, the Mudical Examinar must be notified at	b	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 [X] If Yes, Give Year or Dates:	?	Was Deced If Yes, spec	~	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		ace - Americ ack, White, ify: Whit	etc.
Baltimore, Maryland 21215-0036	led within 72 h yglene. ner than "net	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ade completed) College (1-4or	(Giv	edent's Usua re kind of wor DO NOT us emaker	k done d se retired	luring most			16b. Kind of	ome	dustry
yland	2 should be tiled withind and Mental Hygiene. Is marked other than aumatic event, the M	To Be	17. Father's Name (First, Middle, Las UNKNOWN					unk	now	า	Maiden Suma		
e, Mar	ss 1 and 2 sh of Health and Item 27 is rr other traum		Renee Knisley	friend friend				nd Numbe treet			er, City or Town Derland	n, State, Zio	/D 21502
timor	Part in		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	fy)	Ocarpemii	uneral F	her place lome				Cresa		wn, State
Bal	permit. Departn Imports eny inju	di 1	21. Signatura of Funeral Service Lice 23a. Part1. Enter the disease, or control or the disease.	Idra	well	108	3 Virg	inia Av	enue;		land, MD	21502	
8760, 5	Physician and /Medical Examiner	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Due to (or as c.	a consequence of): a consequence of):								Interval Between Onset and Death
P.O. Box 68	that the death certifica hed by the ettending ph detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pre					1	ate of delive	ry Day Year
	v requires that been signed b should be dete	by	Part II. Other significant conditions of	contributing to death b	- Lucy	underlying ca	use give	n in Part I.	the	23e. Did to	_ /		e cause of death?
tal Reco	The lavate has	e Completed	25. Was case referred to medical								sy med? 2 No	prior to con death?	sy findings available apletion of cause of
Division of Vital Records,	ding Phys n. Atter this funeral di	Certification; To B	examiner? 1 Yes 2 No 27 Manner of Death 1 Natural 5 Pending 2 Accident investigatio				Other	4 Nur	sing Hom		ence 6 Moti ow injury occur		Assisted Living
Divi	ital or Attendurs after deathurs after deathurs lied to by the		3 Suicide 6 Could not b	building, etc	ury - At home, farm, s c. <i>(Specify)</i>					City or Tow	n, State)		Route Number,
	To the Mospital or within 24 hours after To the Funeral Dir completely filled in	Medical	one)	y sician : To the best on niner: On the basis of and manner sta	examination and/or i	ivestigation,	in my opi	nion, deatr	place, ai occurre	nd due to the c d at the time, c	ause(s) and m late and place,	anner as sta and due to	ited. the cause(s)
	To To		29b. Signature and title of certifier	angri	D.		D2	25638		1	Sol. Date signe	Month, D	Oay, Year)
	1		30. Name and address of person who Saturnina Chang	M.D.	4 Bro		Fro	stburg	g MD	21532			
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature								

			For State Registrar	State of M		epartment of Certificate of			jiene 0 0	6 38274
			1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea	th	3. Time of Death
	Physici /Medio		Norman J	ohn	Coulter			Novembe Novembe		006 1:15 a M
	Examir		4a. Facility Name (If not institution, g	ive street and number	er)	4b. City, Town,	or Location of De	ath	4c. County of	Death
			Anne Arundel Med				polis	·	Anne A	rundel
	Funeral	١		Sex 7.7 1 ☑ M 2 ☐ F	Age (In yrs. last birth	Months Davis		n. (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		218–28–1738 Usual Residence of Decedent	24	74 Y	3.		March 3	1,1932 1	Maryland
	land w		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Man Man	tor	MD Calv	ert	Sunde	erland				1 ☐ Yes 2X No
	or 284	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	at Country?
	23a vi	Funeral Director	1940 Valley Lane	!			20689		1	U.S.A.
	r dea	nei	11. Marital Status	12. Was Deceder Armed Force	s?	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? can, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)		American Indian, White, etc.
36	s afte	by Fi	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	□No	1 ☐ Yes 2 💆 No			Specify:	white
8	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f ehow the Madical Examinar must be notified at	ed b	15. Decedent's 1		s:1953–58	ecedent's Usual Occu	nation		16b. Kind of Busin	
15	n n	plet	(Specify only highest g	rade completed)		Give kind of work done ife. DO NOT use retin	during most of w	vorking	TOD. KING OF BUSH	ness moustry
212	d with	Completed	Elementary/Secondary (0·12)	College (1-40		ster machi	nist	1	printing	company
פ	al Hys	BeC	17. Father's Name (First, Middle, Las	it)			18. Mother's N	ame (First, Middle, I	Maiden Sumame)	
Maryland 21215-0036	tges 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If I tem 27 is marked other than "naturet", or items 23a or 28a-f ehow if It tem 27 is marked other than "naturet", or items treumatic event, Inc. Marical Ext. ulter mail be notified at	Tof	Norman James	Coulter			Mary	Magdal:	ine Si	mms
a	and and is my		19a. Informant's Name/Relationship			Mailing Address (Stree				
<u>≥</u> ش	and lealth m 27 her tr		Marie Coulter, w	ife		40 Valley :	Lane, Su	1-1-1		
Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3		te cemetery,	Disposition (Name of crematory or other pla	· 1		20c. Location - Ci	
Ξ	t. Pa rtmer rtant:		4 □ Donation 5 □ Other (Spec		Loudon	Park Cemet			Baltimor	
Bal	Depa Depa Impo eny ir	_	21 Signature of Funeral Service Lice	7	. 1			ausch Fun		
			23a. Pari1. Enter the disease, or co	molications that caus	sed the death. Do no	8325 Mt.				20736 Approximate
			shock, or heart failure. List on! Immediate Cause (Final	y one cause on each	line.	. ^ _ ^		as or respiratory arre	J. J. J. J. J. J. J. J. J. J. J. J. J. J	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	100- CED	NSEK				18mmest
	Examiner			Due to (or a	as a consequence of):				
	4	Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequence of).				
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
ó	e exer en ar irial-ti	Ĕ	resulting in death) Last	Due to (or a	as a consequence of	:				
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	dical		d						
<u> </u>	ing p	Med	IF FEMALE:							
Box	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pregnanc	у		23d. Date of Month	-
o.	res that the de signed by the a be detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐ Pregnant 9∐ Unknown	at time of death	5 Other (specify)				,
۳.	The law requires that the te has been signed by tho page 2 should be detached.		Part II. Other significent conditions	contributing to death	but not resulting in t	he underlying cause gr	ven in Part I.	23e. Did tob	pacco use contribu	ite to the cause of death?
Vital Records,	uires 1 sign 1d be	d by						1 (X Ye	s 2 No 3	☐ Probably 4 ☐Unknown
CO	w require been si should t	lete					-	24a. Was a	n 24h We	re autopsy findings available
Re	hysician: The law his certificate has b I director, page 2 s	Completed						autops perform	y prio ngg? dea	r to completion of cause of th?
		BeC	25. Was case referred to medical				26 Place of D	1 Yes 2 eath (Check only on		Yes 2000
<u> </u>	Attending Physician: r death. ector: After this certifici	TO B	examiner?	Hospital: Inpa	itient 2 ER/Outp	atient 3 DOA Ot	hor	Home 5 ☐ Reside		(Specify)
0	ding Phi h. After thi funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Ir	njury 28b. Tin Day Year) Inju			28d. Describe ho		
Division of	uttendir death. ctor: Al y the fu	Certification:	2 Accident investigate	on			Yes 2 No			
Š	I or Attendation after death Director:	ij	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place of I	Injury - At home, farmetc. (Specify)	, street, factory, office		28f. Location (Sti City or Town		or Rural Route Number,
	Hospital of the hours at Euneral District Tuneral District Tely filled in	Ce								
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	edicai	29a. Certifier 1 Certifying F (Check only onle) 2 Medical Exa	iminer: On the basis and manner	of examination and/	death occurred at the toor investigation, in my	me, date and plac opinion, death occ	ce, and due to the ca curred at the time, da	tuse(s) and manne ate and place, and	er as stated. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		Sidiodi	29c Licen	şe number ş) 29	9d. Date signed (A	Aonth, Dey, Year)
)	->= o		- Wester (1	DIM)	MA	1)	V504	7	11/13	106
	0 . 1		30. Name and address of person who	completed cause of	regith (Item 23a) (T	pe, Print)	D	.00	A D.M	Anna MAII
13	0+1		YETEK V	1219	W EN	x) 417	DETTO	HOP KA	Dann,	710011
	Sta Registr		31. Date filed (Month, Day, Year)		Straffs Signature	4 Scarle	9			,v(t)
3	negistr	:1	I V O V J	TE CHOOL	NUTSELVES S	r KENNEL				

			1 – For State Registrar	State of M	faryland / De <i>C</i>		of Health a of Death	nd Mental	Hygien	711115	38275
	F 500 g		1. Decedent's Name (First, Middle, Las	it)				2. Date	of Death		3. Time of Death
7	Physici /Medic		INROSS	C	OLE				EMBER	ау Year 12 200	6 7:00 AM ^M
	Examir	er	4a. Facility Name (If not institution, give 5823 NYSTROM STR		r)	-	wn, or Location of		4	c. County of Dea	
	.đ. 1	42	5. Social Security Number 6. Se		ge (în yrs. last birthda		CARROLLT(of Birth		GEORGE'S
	Funeral Director			M 2□F	59 Yrs.		ays Hours	Min. (Mont	Day Yea 20 1	947 WAS	thplace (State or Foreign cuntry) SHINGTON, DC
	ד פר פר פר פר פר פר פר פר פר פר פר פר פר		Usual Residence of Decedent								
	anyiar how	_	10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits 12 Yes 2 □ No
	28a-1	ecto	MD PRINCE G	EORGE'S	NEW (CARROLLT			1 10 0	itizen of What Co	
	within 72 hours atter death with the Maryland ene. than "naturel", or iteme 23e or 28e-f ehow fra Modical Evarifical must be notified at	Funeral Director	5823 NYSTROM STRE	EET		10f. Zip Co	784			S.A.	ountry?
	death	era	11. Marital Status	12. Was Deceden		3. Was Deceden	t of Hispanic Orig	in? (Specify Yes	or No-	14. Race - Ame	
9	or ite	Fur	1 ☐ Never Married 2X Married	Armed Forces 1 X Yes 2 ☐ If Yes, Give	No NAVY	If Yes, specify 1 ☐ Yes 2		Puerto Rican, etc	:.)	Black, Whit	e, etc. BLACK
21215-0036	ure!',	d by	3 Widowed 4 Divorced	Year or Dates	:	1 103 21	тно эреспу.			Specify:	DLACK
<u>ה</u>	n 72 l	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Gi	edent's Usual C ve kind of work o . DO NOT use r	lone during most	of working	16b.	Kind of Business	/Industry
77	iene.	фшо	Elementary/Secondary (0-12)	College (1-4or	5+)	TRO DRIV	•			PRIVAT	Ε
٦	othe vent,	Bec	17. Father's Name (First, Middle, Last)		-		18. Mother	's Name (First, M	iddle, Maide	n Sumame)	
Maryland	Menta Menta arked	10	JESSIE COLE				CARR	IE BURT	ON		
Jar	2 short and in mand raum		19a. Informant's Name/Relationship (7	ype, Print)				or Rural Route N			. ,
	1 and Health em 27 ther t		SHIRLEY E. COLE/	WIFE	20b. Place of Dis			V CARROLI		ARYLAND Location - City or	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel; or items 23a or 28a-1 show any futury or other traumatic event, the Medical Examinat must be notified at ance.		1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		s cemetery, c	ematory or othe	r place)				
Ħ	artme orten injur		21. Signature of Funeral Service Licen		MD VETE	RANS CEI 22. Name and A	METERY I ddress of Facility			LTENHAM IS FUNER	MARYLAND
ä	Depariment Department of the procession of the p			\$		7474 LAI	NDOVER R	OAD LAND			20785
ă.	* #		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that cause one cause on each	ed the death. Do not						Approximate Interval Between
de	Physician		Immediate Cause (Finaf disease or condition	C.	ANCER OF L	UNG					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):						
		Ē	Sequentially list conditions,	b. Due to (or a	s a consequence of):						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,							
o Ô	e exec en an rial-tr	Еха	resulting in death) Last	C Due to (or a.	s a consequence of):						
8760,	cate be executed physicien and the burial-transit	dical	(d							
9	n certific anding p use as	/Mec	IF FEMALE:	23c ff yes outcom	o of prognacov						
Вох	eath certifi ettending for use as	Physician/Med	in the past 12 months?		2 Fetal death	☐Ectopic pregr				23d. Date of del Month	ivery Day Year
o.	that the dead by the detached	ysle	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		- Other (specia	,,		_		
ري ص	The law requires that the death certific Ite has been signed by the ettending p tage 2 should be detached for use as	by PI	Part II, Other significant conditions co	ontributing to death	but not resulting in the	underlying caus	e given in Part I.	23e.	Did tobacco	use contribute to	the cause of death?
ğ	w require been sig should b								1 1 ₹ Yes 2	2 No 3 P	obably 4 Unknown
ecc	law r	Completed							Was an	24b. Were au	utopsy findings available completion of cause of
<u> </u>		Co	_						es 2.23.N	death?	
Ž	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospitaf:			Other	of Death (Check of			
ō	Attending Physicien: r death. ector: Atter this certifici by the funeral director,	7: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpat 28a. Date of Inj (Month, D			4 ☐ Nurs	sing Home 5 🛣		6 ☐Other (Spe ury occurred	cify)
<u>0</u>	ath. r: Afte	atlo	1 Avatural 5 Pending 2 Accident investigation		ay Yeer) Injur	м	Work? 1 Yes 2 N	lo			
Division of Vital Records,	for Atten after deat Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	289. Place of Ir	ntury - At home, farm, etc. (Specify)	street, factory, of	fice		on (Street a		ıral Route Number,
Ω	ospital o hours af unerei D ly filled ir										
	T 4 T 0	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	viner: On the bes and mappers	t of my knowledge, de of examination and/or stated.	ath occurred at ti investigation, in	he time, date and my opinion, death	place, and due to occurred at the t	the cause(sime, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1/2		29c. Li	cense number		29d. Da	ate signed (Mont	h, Dey, Year)
_				1/8		D1	9431		NOV	EMBER 17	2006
12	-110)		30. Name and address of person who o	//		e, Print)					
	C		FRANK RYAN M.	.D.: 11701	LIVINGSTO	N ROAD 1	103 FO	RT WASHI	NGTON,	MARYLA	ND 20744
*	Sta Registr	_	NOV 2 0 2006	Beer	trar's Signature						

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			1 - For State Registrar		ryland	d / Depa <i>Cei</i>	artment tificate	t of H	lealth a	and M		giene Reg. No		06	3827	6
	Physici	an	1. Decedent's Name (First, Middle, La	•							Date of De Month	Day	, Y	ear	3. Time of Death	
П	/Medic	~	Elgie Melvi		Co1be	ert					Novembe	er 1	7, 20		12:50A. M	_
	Examin	er	4a. Facility Name (If not institution, given Northampton Mar		7020	Conto			Location o	of Death		4c.	County of		-1-	
		,				ente	If Under		If Under	24 Hrs	8. Date of Bir	*h	Fred			_
	Funeral Director			15ENM 2□F	86	Yrs.	Months	Days	Hours	Min.	March 2	y, Year)	1920	Coun	lace (State or Foreigr try) Cyland	7
			Usual Residence of Decedent							-	riai Cii	20,	1920	rial	Lyland	_
	yland yland		10a. State 10b. County		10c. City,	, Town or Lo	cation							1	0d. Inside City Limits	
	a-f-	tor	Maryland Frederi	.ck	Fre	deric	k								XX Yes 2 □ No	
	로 28 로	Jre.	10e. Street and Number				10f. Zip					_	izen of Wha	at Coun	try?	
	23a	by Funeral Director	200 E. 16th Stree	t			21	701				USA				
	tama de	nue	11. Marital Status	12. Was Decedent E Armed Forces?		5. 13. \	Was Deced f Yes, spec	ent of H	ispanic Ori in, Mexicar	gin? (Spo 1, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Black,	Americ White,		
8	rs aft	γF	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes 2√√N If Yes, Give Year or Dates:	0		1 ☐ Yes 2	2 DXNo	Specify:				Specify:	V	vhite	
3	filed within 72 hours after death with the Maryland Hygiene. Inter then "natural", or flams 23s or 28s-f ehow ent, the Medical Examinar must be notified at	ed	15. Decedent's E			16a. Deced	dent's Usua	Occup	ation			16b. K	ind of Busin	ness/inc	fustry	
<u>ე</u>	n n n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)		(Give	kind of wor DO NOT us	k done d	durina mos	t of worki	ing	105.14		1000		
7	d with	E O	7	College (1-4or 5-	,	Farm	er					Ag	ricul	ture	e	
פ	vent,	Bec	17. Father's Name (First, Middle, Las	1)							(First, Middle,		Sumame)			
<u>a</u>	Menta Menta arked	2	Calvin Colbert						Beula	ah Vi	lola Qu	ick				
al	ages 1 and 2 should be filed within 72 hours after death with the Marylan in of Health and Mental Hygiene and the fire them 28 or 28 or 28 or 6 how it or other traumatic event, the Medical Examinar must be notified at	1	19a. Informant's Name/Relationship Anne Dayhoff -	(Type, Print) niece		19b. Mailir	g Address	(Street a	and Number	or Or Rura	al Route Numbe Woodsbo	er, City o	Town, Sta	ate, Zip	Code) 1 21798	
≥	1 and 2 Health tem 27 other tra		-		1				TO KC							_
Baltimore, Maryland 21215-0036	Pages 1 nent of H int: If ite iry or ott		20a. Method of Disposition 1 Surial 2 Cremation 3	☐Removal from State	Св	ace of Dispo	natory or of	ther plac			Date		cation - Cit	-		
E	. Pa tmen tant: jury		4 □ Donation 5 □ Other (Special		Rock	cy Hil			-		2006	Wood	dsbor	o, N	Maryland	
a D	permit. Page Department of Important: If eny injury of once.		21. Signature of Funeral Service Lice	/1960 //		//			ss of Facilit	. St	auffer	Fun	eral 1	Home	1 1 0170	-
			a. P rt1. Enter the disease, or con	CAKELLE .	(Al								ICK, I	Mary	land 2170	4
			shock, or heart failure. List only	one cause on each line	9.	. DO HOL WHI	er the mode	B OI Gyill	g, such as	cardiac	n respiratory a	11651,			Approximate Interval Between Onset and Death	
,	Physician /Medical		disease or condition resulting in death)			TANT	Un	PH	AAC					_	MONTHS	_
	Examiner			Due to (or as a	consequ	ence of):										
		e	Sequentially list conditions, I ary, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequ	anca of):							***			_
	uted	Examiner	Cause (Disease or injury that initiated events	c												
Š	en an rial-tr	Exa	resulting in death) Last	Due to (or as a	consequ	ence of):								m.		
8/60,	cate be executed obysicien and the burial-transit	dlcal		d												
20	The law requires that the death certificate be executed to has been signed by the ettending physicien and tage 2 should be detached for use as the burial-transit	Med	IF FEMALE:											_		-
X Q Q	eath certific ettending p	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	of pregnan 2 🗌 Fetal		Ectopic pro	egnancy				4	23d. Date o			
7	it the dea by the et tached fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime of de	ath 5□	Other (spe	ecify)					Month		Day Year	
5	that the		Part II. Other significant conditions	contributing to dooth bu	t not room	Nine is the			:a Dawl		22a Did t	-b	an nestrib.	.4. 4. 46	e cause of death?	-
Š,	ires tha signed I be del	by			111011850	ming an mie ui	nderlying Ca	ause give	enin rani.			Yes 2			ably 4 □Unknown	
Ö	w requir been si should I	Completed														
ě	eiaw hasi je 2 s	Id III	Demen	UTIA (ALZ	4571	nens))				24a. Was		24b. We	re autop or to cor	osy findings available npletion of cause of	ý
_	42 CT										1 Yes			Yes	2□ No	
5	ysician: The is certificate h director, page	Be c	25. Was case referred to medical examiner?	Hospital:				Δ Othe	00		(Check only o					
Ö	Phys rthis ral dis	To	1 Yes 2 No	28a, Date of Injury	,	P/Outpatien 28b. Time of		^	4,125,140		me 5 Resident			(Specify)	
0	th. th. After this tuneral	ig l	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigate	(Month, Day	Year)	Injury	м	8c. Injury Work	k? Yes 2 □				,			
Division of Vital Records,	or Attencefter death Director: in by the	E E	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of tnju	ry · At hor	me, farm, str	eet, factory	, office						or Aura	I Route Number,	_
٥	s efte	Certification:	4 Homicide	building, etc.	(Specify))					City or To	wn, State)			
	To the Hospital or Attending Physician: within 24 hours site death of the Funeral Director: After this certific completely filled in by the funeral director,	cal	29a. Certifier 1 Certifying P	hysician: To the best o	f my know	vledge, death	occurred :	at the tin	ne, date an	d place,	and due to the	cause(s)	and mann	er as st	ated.	_
	the H in 24 ihe Fi pletel	edical	one) 2 Medical Exa	miner: On the basis of and manner stat	examinati ed.	ion and/or in	vestigation,	in my of	pinion, dea	in occurr	ed at the time,	date and	place, and	due to	the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	\ \ \			-		e number			29d Da	te signed (/	Month, I	Day, Year)	
				1/1 ~)			1)3	2171				11/1	7/0	6	
1	り		30. Name and address of person who				•									
			R (Cuspe)	L. GOUGU	POB	32	8 W1	nuc	RSUILL	EM	D 21	753				_
	Sta Registr		31. Date filed (Month Cay, Year)	2006 32 angistra	Signat	J A	redu	•								

DHMH 17 Rev 1/2001

		For State Registrar	State of Ma		oartmen e <i>rtificat</i>			and M		gienę. Reg. No.	11116	38277
		Decedent's Name (First, Middle,	Last)						2. Date of Dea			3. Time of Death
Physic /Medi	cal	Robert Lee 4a. Facility Name (If not institution,	Cook		4h City	Town or	Location o		Month Novembe		Year 2006 County of Deatl	10:15 P ^M
Exami	ner	7401 Willow Roa					erick			10.	Frede	
				(In yrs. last birthda			If Under		8. Date of Birt	h		
Funeral Director		287-22-2418	1⊠M 2□F	77 Yrs.	Months	Days	Hours	Min.	(Month, Da) March 1	y, Year)	29 Ohi	nplace (State or Foreign untry) .O
p s		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits
sho	ō			,		1_						1 ☐ Yes 2 ☒ No
15e N	Directo	Maryland Fred 10e. Street and Number	erick	FI	ederic					10a. Citiz	en of What Co	untry?
Mith ag	ā	7401 Willow Roa	d		101124	2170	12				nited S	
ne 23	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	B. Was Dece			gin? (Spe	cify Yes or No Rican, etc.)		4. Race - Ame	ncan Indian,
ther of the same	F	1 Never Married 2 Marrie							Rican, etc.)		Black, White	
rali, c	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 Tes	2 🔯 No	Specify:				Specify: W	hite
72 ho	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dec	edent's Usua	al Occupa rk done di	tion uring most	t of workii	na	16b. Kin	d of Business/	Industry
ighin	dr	Elementary/Secondary (0-12)	Cotlege (1-4or 5-	+) life	e kind of wo DO NOT u							
ygier t,	ပိ		5+		Past		40.14-4-	4. 10.	(F) 1 1 C (-1)		Church	
be fill H of the system	Be	17. Father's Name (First, Middle, La							(First, Middle,	Maiden :	оитате)	
y nould	2	Stanley Lysand 19a, Informant's Name/Relationshi		105 14-	iliaa Addaaa	/C4===4=			Shick I Route Numbe	- China	Town State 7	Tio Code l
d 2 st d 2 st d and 7 ls r trsur					Willo	•			erick,			
1 an Heali		Joyce R. Cook /	wire	20b. Place of Dis					ate		ation - City or	
ages int of tr. If it		1 Burial 2 Cremation		Frederic			1 _	1/17	/06	Frade	oriok	Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itsms 23e or 28a-f show say injury or other traumatic svent, the Medical Examinar must be notified at once.	1	4 ☐ Donation 5 ☐ Other (Special Service Li					-					s, P.A.
Departmin Departmin Sny ir		I VQ	2									yland 21702
		23a. Part1. Enter the dis-tase or c	omplications that caused	the death. Do not e		-					Marine en e-mir	Approximate Interval Between
Physician		shock, or heart failur. List o tmmediate Cause (Final	nry one cause on each lin	Con.	275	D	ene	16	3			Onset and Death
/Medical		disease or condition resulting in death)	a Due to (or as a	consequence of):	1 2	1	e pri Ci	10 110	1			
Examiner		and the second second	b									
D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		t donsaquence of):								
ocuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
ate be executed nysician and he burial-transit	Ã	resulting in ceatin) cast	Due to (or as a	a consequence of):								
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Seath certifical	₩e	IF FEMALE:	23c. If yes, outcome	of pregnancy						,	3d. Date of deli	NAD!
atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	B⊟Ectopic p					٢	Month	Day Year
the d	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		3							
Physician: The law requires that the death certificate this certificate has been signed by the attending physral director, page 2 should be detached for use as the	by Pt	Part II. Other significant condition	s contributing to death bu	it not resulting in the	underlying o	ause give	n in Part I.		23e. Did to	bacco us	se contribute to	the cause of death?
w require been sig should b									101	res 2 🛭	3No 3□Pr	obably 4 Unknown
aw re	Completed								24a. Was		24b. Were au	topsy findings available completion of cause of
The lay	E								autop perfo 1 ☐ Yes	rmed? 🛒	death?	
ding Physician: The In. After this certificate his funeral director, page	Be	25. Was case referred to medical examiner?				-	26. Place	of Death	Check only o			
Physic this ce	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	nt 2 ER/Outpat	ient 3 DC	Othe	r: 4 □ Nu	ursing Ho	ne 5 Afesio	ience 6	□Other (Spec	cify)
5 5 6	i.i.	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time Ye <i>ar)</i> Injur	of 2	8c. injury Work			28d. Describe I	now injury	occurred	,
Attendi	cati	2 Accident investigation inves	t be		М		/es 2 □					
or At or At or At or At or At	Certification;	4 Homicide determin	28e. Place of Inju- building, etc	iry - At home, farm, :. (Specify)	street, factor	y, office		1	28f. Location (3 City or Tox		Number or Ru	ral Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying	Physician: To the best of	of my knowledge de	ath occurred	at the tim	e date as	nd place	and due to the	Calledel	and manner as	Stated
24 hos Fun	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner sta	examination and/or	investigation	, in my op	inion, dea	th occurr	ed at the time,	date and	place, and due	to the cause(s)
ompl	Me	29b. Signature and title of certifier			29	c. License	number				signed (Monti	
F > F 0		> Ain 1	Nayr			DO	0550	06		No	vomber	15,2006
6		30. Name and address of person w	no completed cause of de	eath (Item 23a) (Typ	e, Print)							
5)		Dr. A. Nagy	300 West	9th Stree		ceder	ick.	Mary	land	2170		
	ate	31. Date filed (Month, Day, Year)	32. egistra	1 01 .	Caroli							
Regist	16.	HANDER ED. U			-							

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 4 2006 8:50 P M Physician COOLING November HERMAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY SILVER SPRING OLYMPIC STREET 3501 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Monthel Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 12 M 2□F Yrs. 87 July 8 1919 Maryland 578-16-6942 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland permit. Pages 1 end 2 should be tiled within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or iteme 23a or 28a-f ehow amportant: If item 27 is marked other than "neturel", or iteme 23a or 28a-f ehow porter. 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Silver Spring Md. Montgomery Funerai Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 United States 3501 Olympic Street 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1"MaxYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced WWII 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S. Government Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Defense Purchasing Agent 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Janzen Charles C. Cooling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3501 Olympic Street, Silver Spring, Md. 20906 Sarah Ruth Cooling / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11/18/06 Rockville, Md. Parklawn Cemetery O 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility Muriel H. Barber Funeral Home Thure P. O. Box 5038, Laytonsville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): O. Box 68760 Completed by Physician/Medical as attending tor use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Records, P. signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? COPD has 1 ☐ Yes 2 ☐ No 1 Yes 2 No tai or Attending Physician: T s after death. el Director: After this certiticate ed in by the funeral director, pa Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1. X Natural 5 Pending 1 Yes 2 No М investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 Homicide filled To the Hospital within 24 hours a To the Funerel I Hospitai 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2006 ddess of person who completed cause of death (Item 23a) (Type, Print) 7+1 20895 KENSINGTON, MD. 10810 CONNECTICUT AVE., JEFFREY DROBIS, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

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		_	1 - State Registrar			Cert	ificate of	Death		R	eg. No	106	38279
≘ş PI	hysicia	an	1. Decedent's Name (First, Middle, La	st)						Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Edith Corenfield				4. 6" T	,		Nov. 8	_		5:55P ^M
E	xamin	er	4a. Facility Name (If not institution, given Bedford Assisted	· · · · · · · · · · · · · · · · · · ·			4b. City, Town, o Silver					inty of Death	
Fu	neral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. last I	birthday)	If Under 1 Year	If Under 2	24 Hrs. 8.	Date of Birth			y place (State or Foreign
	ector		578-40-9999	□M 2 1 91		Yrs.	Months Days	Hours	Min. Fe	(Month, Day	1915	Cou	ntry) ginia
pu ;	2		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	ation						404.4
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the A	z8a- notifi	Director	MD Montgome 10e. Street and Number	ır y	ROCKV	TITE	10f. Zip Code			1	On Citizen	of What Cou	
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deat	ems s	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	lispanic Orig	gin? (Specif	y Yes or No-	14. F	Race - Americ	
affer	mine		1 Never Married 2 Married	1 Tes 2 1 N	10		Tes, specify Cuba	Specify:	i, ruerio nic	cari, etc.)	i	Black, White,	, etc.
bours 1	al Exa	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	10			,				Wh	nite
75 ri	fedio	plete	15. Decedent's Ed (Specify only highest gra	ide completed)	117	(Give k	ent's Usual Occup ind of work done of O NOT use retired	iation during most d)	of working	1	16b. Kind of	f Business/In	ndustry
212 d with giene	the	mo	Elementary/Secondary (0-12)	College (1-4or 5	+)		emaker				Own	Home	
al Hys	orner man natural , or nems 23a or 28an snow event, the Medical Examiner must be notified at	Be Completed	17. Father's Name (First, Middle, Last,)				18. Mothe		irst, Middle, I	Maiden Surr	name)	
aryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	atte e	٦ ا	Harry Neff								Blum		
E al	er traum		19a. Informant's Name/Relationship (Eileen J. Poling		er	9b. Mailing 1040	Address (Street 4 Strath	and Numbe I more	r or Rural F Park	Route Number #401 R	r, City or Tov .ockvi	wn, State, Zip 11e, M	D 20852
es 1 es 1 es 1 es 1 es 1 es 1 es 1 es 1	r oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☒	Pamoual from State	20b. Place ceme	of Disposi	tion (Name of atory or other place	ce)	Date	Э	20c. Locatio	on - City or To	own, State
Limor Pages tment of	Jury o		4 ☐ Donation 5 ☐ Other (Specif	y)	King		d Memori		1110-			Church	=
Baltimore, permit. Pages 1 ar Department of Heal	any In		21. Signature of Furieral Service Licer	nsee		22.	Name and Address 1091 Roc						irection 20852
100			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. De	o not enter	the mode of dyir	ng, such as	cardiac or re	espiratory arr	est,		Approximate Interval Between
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C 68	as th	Med	IF FEMALE:										
The law requires that the death certification is the bean climed by the attending	for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal dea		Ectopic pregnancy	/				Date of delive	ery Day Year
S e e	tached f	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5□0	Other (specify)					WOTH	Day real
that the	be detac		Part II. Other significant conditions of	ontributing to death bu	ut not resulting	j in the und	erlying cause give	en in Part I.		23e. Did tot	pacco use co	ontribute to t	he cause of death?
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VITAI Sician: T	rector, page 2 s	Be C	25. Was case referred to medical examiner?					26. Place	of Death (C	check only on	e)	1 ☐ Yes	
<u> </u>	20	2	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatie				er: 4 🗆 Nur	sing Home	5 ☐ Reside	ence 6XIC	Other (Specif	Assisted Living
DIVISION OF I or Attending Phy after death.	r. Alter	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day		o. Time of Injury	28c. Injur Worl	yat k? Yes 2 □ N	280	I. Describe ho	ow injury occ	curred	
IVIS or Atte	n by th	rtific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju	ry - At home, c. (Specify)	farm, stree	et, factory, office		28f.	Location (St. City or Town	reet and Nu	mber or Rura	al Route Number,
pital o	filled		29a. Certifier 1X Certifying Ph	ysician: To the best of	of my knowled	no doath	accurred at the tir	no data and	d place and	1 de a 4 de a -			
DIVISION C DIVISION C To the Hospital or Attending P within 24 hours after death. To the Funeral Director. After the	mpletely	Medical	one) 2 Medical Exam	niner: On the basis of and manner sta	examination a	and/or inve	estigation, in my o	pinion, deat	th occurred	at the time, d	ate and plac	ce, and due to	o the cause(s)
8	8	-	29b. Signature and title of certifier	55 105			29c. License D0505			25	9d. Date sig 11 -9-	ned (Month, 06	Day, Year)
			30. Name and address of person who Godswill Okoji, M	completed cause of de ID 7513 New	eath (Item 23a V Hamps	n Type, Pi	Äve. Tal	koma I	Park,	MD 200)12		
R	Sta egistr		31. Date filed (Month, Day, Year) NOV 1 6 2	006 32 legistra	r's Signature	Mas	di						

	For State Registrar	State of Ma	aryland / Depa		f Health and		ygiene Reg. No. 200	6 38280
Physician /Medical Examiner	1. Decedent's Name (First, Middle, La	A. C/1	DCL	4b. City, Tow	n, or Location of Dea		ber 8, 2006	1:42 P. M
Funeral Director			o (In yrs. last birthday) 53 Yrs.	Beth If Under 1 Ye Months Da			Montgo irth lay, Year) 9. B 23, 1953 Wa	mery irthplace (State or Foreign Country) shington, D.(
death with the Maryland may 23a or 28a-1 show rimest to notified at neeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo	omery	10c. City, Town or Lo Bethesda					10d. Inside City Limits 1 □ Yes 2 □ No
J36 us after death with the Main in the Main in the Main in the Main in the m	7401 Westlake Tel	12. Was Decedent E		10f. Zip Cod 2081 Was Decedent		Specify Yes or N	U . S .	A .
1215-0036 within 72 hours after and then "naturel", or Its Medical Exacutation properties by Furnitude and Second	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E	1 Tes 2 N If Yes, Give Year or Dates:	lo 16a Dece	1 ☐ Yes 245	No Specify:		Specify: W	hite
Baltimore, Maryland 21215-0036 Semit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The matter than "naturel", or any injury or other treumatic event, the Medical Exercising injury or other treumatic event, the Medical Exercising injury or other treumatic event, the Medical Exercising injury or other treumatic event, the Medical Exercising injury or other treumatic event, the Medical Exercising injury or other treumatic event, the Medical Exercising injury or other treumatic event, the Medical Exercising injury or other treumatic event, the Medical Exercising injury or other treumatic event, the Medical Exercising injury or other treumatic event, the Medical Exercising injury or other treumatic event, the Medical Exercision in the Exercision in	(Specify only highest gi Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Las	College (1-4or 5 4 Years	+) Chief		ine during most of w tired) ic Affair 18. Mother's Na	S	U. S. Gov	ernment
Maryland 2121 nd 2 should be filed within lith and Mental Hygiene. 27 is marked other then " r treumatic event, tre Me To Be Compi	Harvey Chide: 19a. Informant's Name/Relationship Harvey Chidel -	(Type, Print)			eet and Number or F		ber, City or Town, State	
more, M Pages 1 and 2 ent of Health 1 m: If Item 27 I	20a. Method of Disposition 1 \(\sum_{\text{Burial}} 2 \sum_{\text{Cremation}} 3 \) 4 \(\sum_{\text{Donation}} 5 \sum_{\text{Other}} \((Spec	☐Removal from State	20b. Place of Dispo cometery, crea	sition (Name or natory or other	place)	Date 2/2006	" Mary1 20c. Location · City of Olney, Ma	
Baltimory permit. Pages i Department of the Important: If its any injury or of sone.	21. Signature of Funeral Service Lice	Stottle	nyer !	dward	dress of Facility agel Fune	ral Dire ke, Rock	ection, Inc	\$1and 20852
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P.O. Box 68 nat the death certificat d by the ettending phy letached for use as the physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □₩o 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregna Other (specify			23d. Date of d Month	elivery Day Year
SCORDS, aw requires the spen signer of the spen sig	Part II. Other significant conditions HEAVE FALLORE BILLIAM Prev		ut not resulting in the u	nderlying cause	given in Part I.	1 🗆 24a. Wa auto	s an 24b. Were prior to	Probably 4 Unknown autopsy findings available o completion of cause of
n of Vital ng Physician: ther this certifical ineral director, 1	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Unpaties 28a. Date of Injur (Month, Day	y 28b. Time o	f 28c. [Other	1 ☐ Yes eath <i>Check only</i> Home 5 ☐ Res		es 2 No
Division of Division of Alter I after death. Treat Director: After I lied in by the funeraction:	2 Accident investigation 3 Suicide 6 Could not determined	28e. Place of Injubulding, etc		eet, factory, off	Се	City or To	(Street and Number or I own, State)	
Divisio Divisio To the Hospital or Attendit within 42 hours after death. To the Funeral Director: A completely filled in by the funeral Director A dedical Certificati	29a. Certifier (Check only one) 29b. Signature and title of certifier	hysicien: To the best of miner: On the basis of and manner sta	examination and/or in	vestigation, in n	e time, date and place by opinion, death occurrence number	ee, and due to the curred at the time	e cause(s) and manner, date and place, and di	ue to the cause(s)
State Registrar	30. Name and address of person who RALL V · Bock State of the Bock	1A, MD 6	eath (Item 23a) (Type, POUC tr's Signature	10065	DV. 1	Berten	x, no	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician Matilda Helene Callaway 13, 2006 8:10P. November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Manor Care Silver Spring
| If Under 1 Year | If Under 24 Hrs. |
| Months | Days | Hours | Min. | Montgomery 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Nov. 4, 1930 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 76 1 ☐ M 2 💢 F 577-36-6565 Washington, DC Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: if item 27 is marked other then "natural", or Itema 23a or 28a-f show ury or other traumatic event, the Medical Examinat must be notified at Maryland Prince George's Adelphi 1 Yes 2 No Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2404 Lackawanna Street 20783 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. white 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Badini Angelo James Crescenza Nicastri 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert J. Callaway -son 11206 Poplar Grove Court Laurel, Maryland 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 11/17/2006 Silver Spring, Maryland 1 4 □Donation 5 □Other (Specify) Bonald V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licenses 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lung Cancer **Physician** 1 year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Lung Disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sacral Decubitus; failure to thrive 1 Yes 2 □ No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has this certificate ha 1 Yes 2 No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 1 (2) Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Alter Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours a To the Funeral I To the Hospital 15

Division of Vital Records, P.O. Box 68760

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D19609 29d. Date signed (Month, Dey, Year)

November 15, 2006

06-08689 Montana Cherry

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ Month November 15, 2006 0340 hrs Medical Examiner Cherry Montana 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number Age (In vrs. last birthday) **Funeral** Months Days Hours oreign Min Director 220-75-4434 CouMaryland M 2 X F 3 08/01/2006 14 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County any 10a. State 1 X Yes 2 No 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho or items 23a or 28a-f sho must be notified at once. Maryland Anne Arundel Severn Director 10f. Zip Code 10g. Citizen of What Country' 10e. Street and Number 1804 Arwell Court 21144 United States 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc African Armed Forces? 1 X Never Married 2 Married Yes f Yes, Give Year Yes 2 No specify: American Widowed Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than ' Baltimore, MD 21215-0036 None None None 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glen R. Cherry Dameka C. Randolph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dameka Clarise Randolph/Mother 1804 Arwell Ct., Severn, MD 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition Date crematory or other place) 1 X Burial 2 Cremation Memorial Park 11/24/06 Harmony Donation 5 Other Specify Landover, MD 22. Name and Address of Facility nature of Funeral Service License Stewart Funeral Home 4001 Benning Rd., NE Wash. , DC 20019 It I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or **Physician** Between Onset and re. List only one cause on each line /Medical Death Sudden unexplained death in infancy Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed and ian/Medical X UNPENDED attending physician or use as the burial #23a,27,28a-f perME. g863m. 1/22/07 TT Division of Vital Records, P.O. Box 68760, 23d Date of delivery IF FEMALE 23c. If ves, outcome of pregnancy Was decedent pregnant in the Month Day Live birth Fetal death Ectopic pregnancy Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Physici 1 Yes 2 V No 9 Unknown Unknown detached 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I \$ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 2 No Yes 2 1 🗸 Yes certificate 25. Was case referred to medical 26.Place of Death (Check only one the Hospital or Attending Physician: Be Other₄ Hospital: 1 Inpatient 2 PER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death After Certification: Natural Yes 2 X No n 24 hours after death

te Funeral Director: A
bletely filled in by the fi Pendina Fnd 11/15/2006 Fnd 2:40am unknown Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) Suicide 1804 Arwell Ct. (Specify) Severn, MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started To the F 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 15, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygien Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Arthur November 14, 2006 Dunston 19:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** MXM 2□F 62 579-56-3787 Yrs. 12-18-1943 Director Bunn NC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hyglene. Important: If item 27 ie marked other then "naturel", or iteme 23a or 28e-f ehow any njury or other treumatic event, the Madical Examinar must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director Prince George's Ft. Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20744 6851 Southfield Rd Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status No 1962 ITYes, Give Year or Dates: 1964 1 Never Married 2 Married Baltimore, Maryland 21215-0036 SpecifyBlack 1 ☐ Yes 2 ☒No ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bus Operator Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Moses Dunston Etless Rodgers 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Dunston/Wife 6851 Southfield Rd Ft. Washington MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place Gethsemane Bapt. 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 11-19-2006 4 ☐ Donation 5 ☐ Other (Specify) Bunn, NC Church Cemetery 21. Sign wre of Funeral Servi Licensee 22. Name and Address of FacilityPope Funeral Home 2617 Penn Ave SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypoxic Encephals pathy Unknow. /Medical Examiner LAKTOWA Myscardial Securities, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to r as a consequence of) Examine physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical ate has been signed by the attending phys page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Runknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🐼 No Certification; To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death.
I Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide To the Hospital of within 24 hours at To the Funeral Discompletely filled it Hospital 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43446 Familia M.D. Reinten 11.15.06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4801 Georgia Are Sait 3-41 Silverspring MD 20902 MD. ROINTAN FARAHIFAR 31. Date filed (Month, Day, Year) NOV 2 0 2006 32. Registrar's Signature State Registrar

		-	1 - For State Registrar	State of	Marylan	d / Depa <i>Cer</i>	artment of He tificate of D	ealth and l Death		giene2 () () 6	38284
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	/Medic Examin		4a. Fecility Name (If not institution, gir		nber)		4b. City, Town, or	Location of Deat		4c. County of Dea	
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ı	Funeral Director		577-68-7258	Sex 1□M 2 Q F	7. Age (In yrs.) 55	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day 1/5/50	Year) 9. Bir C Wa	thplace (State or Foreign ountry) Sh., D.C.
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation				10d. Inside City Limits
	Maryl	to	Md.	P.G.		Seat	Pleasant				1 ☐ Yes 2 ☐ No
	or 28a	lirec	10e. Street and Number	_			10f. Zip Code		1	0g. Citizen of What C	ountry?
	eth wi	rai	722 Cabin Bra				207			U.S.A.	
396	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, its Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Dece Armed For 1 Tyes If Yes, Give Year or Da	2 ∑ No 9	1	Vas Decedent of His fYes, specify Cubar □ Yes 25 No	spanic Origin? (S i, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi	te, etc.
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ary	2 should and Men is marke	-	19a. Informant's Name/Relationship				•	nd Number or Ru	ıral Route Numbei	r, City or Town, State.	
	1 and 2 Health tem 27 other tr		Dominique V. Wes 20a. Method of Disposition	t/Daugnt			Cabin Bra	nch Dr.	1	easant, Md.	
Baltimore,	Pages Inent of Hunt: if ite		1 Burial 2 Tremation 3 (State	emetery, crer	natory or other place	1		06 Beltsvil	
Balti	permit. Pages Depertment of I important: if its any injury or o		21. Signature of Funeral Service Lice	nsee Pro		22	. Name and Address H.S.Washi	of Facility noton &	Sons Co.	.,Inc. ashington,	
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a)(101	16 51-	HOCK			Onset and Death
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8760,	cate be executed physicien and the burial-transit	dical		d							
Box 6	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		rth 2 ☐ Fetel ant at time of de	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
P.0.	thet the	, Phy	9 🗹 Unknown Part II. Other significant conditions	contributing to de	ath but not resi	ulting in the u	nderlying cause give	n in Part I.	23e. Did tol	bacco use contribute to	o the cause of death?
rds	w requires the been signed I should be det	ed by							1 🗆 Y	es 2 □No 3 □ P	robably 4 @Unknown
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ō		2:1	1 ☐ Yes 2 ■ No 27. Manner of Death	28a. Date o	of Injury	28b. Time of	1 3 DOA	4 Nursing r		ence 6 Other (Spe ow injury occurred	ecify)
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	To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edicai			sis of examina					ause(s) and manner a late and place, and due	
	With:	Σ	29b. Signature and title of certifier	() 1	10		29c. License	6358	_	9d. Date signed (Mont	
D	(2)		30. Name and address of person who	completed caus	e of death (Item	-	Print)				
<i> </i> -	Sta	te.	300 \ Hosh (31. Date filed (Month, Day, Year)	tal U	egistrar's Signa	(hlur		10207	82. 1	lina H.	lacoub.
	Registr		NOV 2 0 2006	Beren	egistrar's Signa	Sperke					

DHMH 17 Rev 1/2001

Amend Item 25 State of Maryland / Department of Health and Mental Hygiene per dr., 8866,04/18/07dhb Certificate of Death 38285 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Darland November 16, 2006 11:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** College View Center Frederick Frederick If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 568-24-8682 If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days 1 ☐ M 2 🖾 F June 6, Director Iowa Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar manned to account the market and the property. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Frederick Frederick Maryland 1X Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 Toll House Avenue 21701 IISA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Assembly Worker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertram Darland Alyce Comfort P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Lee/Son 1592 Dockside Drive, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/19/06 Frederick, MD Frederick Crematory 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Fun Service I 1621 Opossumtown Pike, Frederick, MD 21702 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, early one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Due to (or as a consequence of) Physician/Medical Examiner the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≱ No ို 27. Manuer of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Tyes 2 TNo 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11-17-2006 D0060417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas JOHNSON DR. Frederick MD 21702 Hemen State 2006 Registrar

		•	For State Registrar	State of Maryl		artment of H rtificate of L		ientai Hygie _{Reg.}		00200
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
7	/Medic	al .	LARRY JOSEPH 4a. Facility Name (If not institution, give st	DUPERRON root and number)		4b City Town or	Location of Death	Novembe	4c. County of Dea	-41.
	Examin	er	WASHINGTON COUNT			- "	AGERSTOWN	1		SHINGTON
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye	0.00	rthplace (State or Foreign ountry)
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	or 28%	Director	10e. Street and Number			10f. Zip Code		10g.	. Citizen of What C	
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36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No lif Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2ሺ No		Rican, etc.)	Black, Whi	
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Maryland	should and Men Is marke	F	19a. Informant's Name/Relationship (Typ	*				al Route Number, C		
	1 and 2 Health a em 27 Is ther tra		STELLA N. DUPERRON							IARYLAND 21782
Baltimore,	0 0 - -		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State		matory or other plac	re)		c. Location - City o	
Iţim	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Fundral Service License			RG CREMAT 2. Name and Addres		7606 OLD		, MARYLAND
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Į.			23a. Part . Enter the disease, o Complic shock, or heart failure. List only on	ations that caused the or cause on each in e.	death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
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	tificate ng phy as the	Aedical								
Вох	death certifi attending I d for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	sc. If yes, outcome pf pr 1 ☐ Live birth 2 ☐	Fetal death 3	⊒Ectopic pregnancy	,		23d. Date of de	elivery Day Year
	he dez the at thed fo	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify)			11101111	Day Tour
, P.O	that the de led by the a detached		Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute t	to the cause of death?
rds	quires en signe uld be	ed by						1 ☐ Yes	2 □ No 3 □ F	Probably 4 Unknown
or Vital Records,	ne law requir has been si ge 2 should	Completed						24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
<u>=</u>	The ate h	Com						performe	d? death?	s 2□No
Vita	Physician: The this certificate har al director, page	Be	25. Was case referred to medical examiner?	ospital:		ot actions Other	or:	(Check only one)		
ō	Phys er this eral dir	- To	1 Yes 254No	28a. Date of Injury	2 ER/Outpatier 28b. Time o	IL 3 L DOA	4 LI Nursing Ho	me 5 Residence 28d. Describe how		ecify)
ion	Attending r death. ector: After by the fune	atior	1 Accident 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Injury		Yes 2 □ No			
Division	ii or Atte after dea i Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - building, etc. (S)	At home, farm, str pecify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or F State)	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C		ician: To the best of my er: On the basis of exa and manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License	e number	29d	. Date signed (Mon	nth, Day, Year)
)				152	555	1/20/6	5
0.6	SH-L		30. Name and address of person who con	mpleted cause of death	(Item 23a) (Type,	Print)	11-	8A 1	9 1711 4	
1	Sta	ate.	31. Date filed (Month, Day, Year)	32. Registrar's S	g Upal Signature	Court	, (1774	· Md	21180	
16,	Regist		NOV 2 7 200	6 Anne	S. An	ander				

	1	For State Registrar	State of Maryl		epartme C <i>ertifica</i>			Re	g. No.	38287
Physiciar /Medica		1. Decedent's Name <i>(First, Middle, Last)</i> Leon Leop					1	2. Date of Deat Month November	Day Year	3. Time of Death 10:30 AM
Examine Funeral Director	4	4a. Facility Name (If not institution, give 1713 West Sevent 5. Social Security Number 6. Sec. 1217-28-5749	n Street, Ap	yrs. last birth	F	reder	i.ck If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 16,	4c. County of Deat Frederi	
D D		Usual Residence of Decedent 10a. State 10b. County Maryland Frederi	10c	. City, Town	or Location rederic	k		100 100	1334	10d. Inside City Limits 1 ★ Yes 2 □ No
ufer death with the Mark items 23a or 28a-fernantified		10e. Street and Number 1713 West Seventh	Street, Apt	. 1	10f. 2	ip Code	21702	10	Og. Citizen of What Co	untry?
ind 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or items 23a or 28a-f show event, the Medical Exeminar must be notified at	2	11. Marital Status 1 □ Never Married 2 □ Married 3 🌣 Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 KN Yes 2 □ No 1 If Yes, Give Year or Dates: 1			edent of Hi ecify Cuba 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: V	
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene. the marked other than "naturel", or traumatic event, the Medical Exem To De Completed by	חווויוויויייייייייייייייייייייייייייייי	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5+)	16a. [Decedent's Us Give kind of v life. DO NOT Posta	ual Occupa ork done d use retired, Serv	ition furing most of work) /ice	ing	6b. Kind of Business Mail Proce	
yland 21 nould be filed w Mental Hygier harked other th natic event, th	ם ב	17. Father's Name (First, Middle, Last) Joseph Albert	Eyler				18. Mother's Name Mildred	e (First, Middle, M Leona	faiden Sumame) Cockrell	
y, Maryle and 2 should eath and Mer n 27 ie marks ner traumatic		19a. Informant's Name/Relationship (Ty Linda Kefauver, Da							City or Town, State, 2 erson, Mar	zip Code) yland 21755
More		20a. Method of Disposition 1			Disposition (No.), crematory of Vet Cer				Prederick,	
Departm Departm Importe eny inju		21. Signatur of Funeral Service Oceans	_	0706	Keene 106 E	and Addres y and ast C	s of Facility Basford hurch St.	PA Fune:	cal Home rick, MD 2	1.701
hysicien be executed by the purish read in the purish reads in the	Lya	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Lany, hearing 1 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	isequence of	ane	at T	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
1		in the past 12 months?	3c. If yes, outcome of pre 1 □ Live birth 2 □ f 4 □ Pregnant at time 9 □ Unknown	Fetal death	3 □Ectopic 5 □ Other (23d. Date of del Month	ivery Day Year
	5	9 □Unknown Part II. Other significant conditions col		resulting in	the underlying	cause give	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?
	Completed	OS Was assessed to a self-self-self-self-self-self-self-self-							prior to death? No 1 □ Yes	topsy findings available completion of cause of 2011No
OT VITA Physician: this certific al director,	2	1 193 50140	lospital: 1 Inpatient				^{9r:} 4□Nursing Ho		nce 6 □Other (Spe	cify)
SIOD (Itending I death. tor: After the funer	meanon	27. Manner of Death Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Yea 28e. Place of Injury - / building, etc. (Sp	At home, farr	jury M		at ? ∕es 2 □No	28d. Describe ho 28f. Location (Str. City or Town	reet and Number or Ru	ıral Route Number,
To the Hospitel or Al within 24 hours after or To the Funerel Direct completely filled in by	enical cel	29a. Certifier 1 Certifying Physical Examions)	sician: To the best of my	knowledge, mination and	death occurre /or investigation	d at the tim	e, date and place, pinion, death occurr	and due to the ca	use(s) and manner as ite and place, and due	stated. to the cause(s)
		29b. Signature and title of certifier	and manner stated.			9c. License D 475		1	November 2	
8		30. Name and address of a rson who co	.D., 1564 O	possum	ntown F	ike,	Frederic	k, MD 21	702	
State Registra		31. Date filed (Month, Day, Year)	32. Rafistrar's S	ignature	book	والم				

			State	e of Maryland	-	artment <i>rtificate</i>			nd Me			2000	0000
		A	Registrar 1. Decedent's Name (First, Middle, Last)		Cei	uncate	OI D	eaur	2.	Date of Dea	Reg. No.	ZUUb	3. Time of Death
	Physicia		HENRIETTA	J EYLER					No	Month ovembe	r 14.	Year 2006	10:48 P ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and	d number)	-	4b. City, T	own, or L	ocation of				unty of Death	
7			Frederick Memorial Ho			Fred						ederick	
6.	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday) Yrs.		Year Days	If Under 2 Hours	Min.	Date of Birti	v, Year)	Coun	
1	Director		164-28-6738 Usual Residence of Decedent	71					Αt	ig.8,	1935	Penns	ylvania
	yland now at		10a. State 10b. County		Town or Lo							1	0d. Inside City Limits
	a-f st	ctor	Maryland Frederick	Thu	ırmont	;							1X Yes 2 No
	h with the 23a or 28 st be no	Funeral Director	35 Catoctin Highland (Circle		10f. Zip 0	1788				10g. Citizer US.	n of What Cour A	ntry?
5-0036	filed within 72 hours after death with the Maryland Hygiene. After than "natural", or items 23a or 28a-f show with, the Medeal Examiner must be notified at	ρ	1 Never Married 2 Married 1 1 Fye	Decedent Ever in U.S d Forces? ∕es 2 Mano s, Give or Dates:		Was Decede f Yes, speci 1 ☐ Yes 2	y Cuban	panic Orig , Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No- can, etc.)		Race - Americ Black, White, pecify: Whi	etc.
Ö	72 hor	sted	15. Decedent's Education (Specify only highest grade comple	ted)	16a. Dece	dent's Usual	Occupat	tion uring most	of working		16b. Kind	of Business/Ind	dustry
Maryland 2121	ges 1 and 2 should be filed within 72 hc t of Health and Mental Hyglene. If item 27 is marked other than "natu or other traumatic event, the Merkell	Completed		ge (1-4or 5+)		kind of work DO NOT use omemak		g ///ooi			Own	Home	
Pu	e file al Hy d othe	Be	17. Father's Name (First, Middle, Last)				1			First, Middle,		. '	
yla	ould to	၉		lley,	Sr.			Hele			Wa		
Mar	12 sh sh and 7 is m traum		19a. Informant's Name/Relationship (Type. Print) Gregory L. Eyler/Son)	l .							own, State, Zip MD 2178	*
	permit. Pages 1 and 2 Department of Health Important: If item 27 i any Injury or other tra once.		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name	e of		Date			tion - City or To	
JOH.	Pages nent of h int: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify)	rom State I		matorý or otl c Crem		' i	1/12/2	2006	Frede	rick, M	ID
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Furieral Service Accensee	120				- 1	-			al Home	
ä	permi Depa Impo any Ir		Kosamue	_	10)4 E.	Main	Stre	eet, I	Thurmo	nt, M	D 21788	B
	Physician		23a. P.m. sto the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the disease or cardiac or respiratory arrest, in the disease or condition.										
Y.	/Medical		resulting in death)	e to (or as a consequ		3111	- 11		<u> </u>	10 CU	(13		1 working
W.	Examiner	_	Sequentially list conditions, b.										
No.	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a consequ	ence of):								
	cate be executed oblysician and the burial-transit	xar	that initiated events c	e to (or as a consequ	ence of):								
8760,	e be e sician b buris	dical E											
9	g phy as the	ledic	u.										
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	s, outcome pf pregnar Live birth 2□Fetal Pregnant at time of de Jnknown	death 3	⊒Ectopic pre ⊒ Other (spe					230	I. Date of delive Month	ery Day Year
P.0	that I		Part II. Other significant conditions contributing	to death but not resul	Iting in the u	nderlying ca	use giver	n in Part I.		23e. Did to	obacco use	contribute to the	ne cause of death?
rds	quires in sign uld be	q pe	Pulmonary en	bolus						101	res 2	No 3 ☐ Prob	ably 4 □Unknown
Seco	e law re has bee e 2 sho	Completed by								24a. Was	sv	24b. Were auto	psy findings available mpletion of cause of
a H	i: The										rmer? 2 No	1 ☐ Yes	2 □ No
<u>K</u>	siciar certif	Be c	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 Inpatient 2 □ E	=P/Outpation	nt 3 □ DOA	Other	r-		Check only o		70th (Cif	
Division or Vital Records,	Attending Physician: r death. ector: After this certific by the funeral director,	ion: To	27. Manner of Death 1 Natural 5 Pending	/	28b. Time of Injury		c. Injury Work?		280	d. Describe h		Other (Specificcurred	y)
isid	Attence death	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e.	Place of injury - At hor	ne, farm, sti			00 2		Location (S	Street and N	lumber or Rura	il Route Number,
Ö	safter safter at Dire	Serti	4 Homicide determined	building, etc. (Specify,) 					City or Tou	vn, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	29a. Certifier (Check only one) Certifying Physician: T										
	To the vithin To the comp	Me	29b. Signature and title of certifier			29c.	License	number				signed (Month,	*
	\sim		Jone A. In	~ WIN			121	144	-		111	15/0	9
	8		30. Name and address of person who completed	cause of death (Item	23a) (Type,	Print)	y A	ve =	#204	Fre	den	X, M	d. 71702
(ca	Sta Regist		31. Date filed (Month Day Year) 2006	32. egistrar's Signat	K A	berli	,						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1COV Dasta If Under 24 Hrs. ff Under 1 Year Date of Birth (Month, Day, Year 3/27/1948 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 [X M 2 □ F Director 58 214-46-4276 Maryland Usual Residence of Decedent 10d. fnside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f ehow 1X Yes 2 No Director Delaware Sussex Delmar the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 E. Delaware Ave. 19940 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ŽNo If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify: Specify: white à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry The Mis Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Disabled none Ith and Mentel Hygie 27 Is marked other r traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cora Marie Smith William Stewart Fields Sr. ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 Baptist St., Salisbury, MD 21801 H. Michael Hickson/attorney f Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: if it any injury or o 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/17/06 Shad Point Cemetery Salisbury, MD Service Licensee HOTTOWAY Puneral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Mompson Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cor KINSON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes ONE 3 Probably 4 Unknown certificate hes been s rector, page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 1 🗌 Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Medical Certification: To Be 26. Place of Death | Check only one Hospital: Other: patient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, 32. Registrar's Signature State 6 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 006 38290 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 20, 2006 Norma Steele George November 1130 A M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Calvert Manor Healthcare Center Rising Sun 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 💢 F Yrs. NOV Mary1and 1930 Director 213-28-0139 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Important: If item 27 is marked other then "natural", or items 23s or 28s-f show eny injury or other traumatic event, it a Madical Execution must be notified at once. 1 ☐ Yes 2 📉 No Director Cecil E1kton Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 United States 109 Walnut Lane Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 🏋 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Efementary/Secondary (0-12) College (1-4or 5+) Secretary Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental Hint: If item 27 is marked of Laird C. Steele Mae E. Scarborough ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lisa George/Daughter 9 Rene Carr Street, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State West Chester, 20a. Method of Disposition November permit. Pages Department of It 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. 21, 2006 Pennsv1vania 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heer failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Hepatic **Physician** /Medical resulting in death) Due to (or as a consequence of): epatitis Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit the Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ signed b Part If. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2000 this certificate 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2**X0**10 2 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Jatural 2 Accident 5 Pending investigation 1 Yes 2 No Director: 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier completely Medi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 00058354 Name and address of person who completed cause of death (Item 23a) (Type, Print) Way Rising Sun, MD 101 COLONIAL E. LATTIN. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 3 0 2006

State of Maryland / Department of Health and Mental Hygien () Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 2006 **Physician** 16 8:24 A M GARRETT JOSEPH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHEVERLY PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
SOUTH CAROLINA 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Social Security Number **Funeral** Months Days Hours 1 ☑ M 2 □ F 68 Yrs. 248-60-7757 JUNE 6 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ahow! r than "natural", or iteme 23a or 28a-f ahor Tra Medical Examinar musi ba notified at 1 XYes 2 No RIVERDALE PRINCE GEORGE'S Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20737 5208 59th AVENUE death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 전 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☑ Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) other than Elementary/Secondary (0-12) GOVERNMENT TRUCK DRIVER 3rd 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) .. Pages 1 and 2 should be fil treent of Health and Mental H tant: If item 27 is marked oft jury or other traumatic avan Be CLEORA FREELAND TANDY GARRETT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7908 CAWKER AVENUE GLENARDEN, MARYLAND 20706 PATRICIA GARRETT/NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Feremation 3 Removal from State Department Important: It any injury o 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY | 11/25/2006 RIVERDALE MARYLAND permit. 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funerans 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Linknown Physi 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No No 1 ☐ Yes is effer deau... ral Director: After this ceru... 25. Was case referred to medical examiner? 26. Place of Death (Check only Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Werner of Death 28a. Date of fnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 A atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide filled in To the Hospital within 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 0 2006

Registrar

		•	1 - For State Registrar	State of Ma	aryland / Dep. <i>Ce</i>	artment of H <i>rtificate of l</i>			giene Co	00272
			Decedent's Name (First, Middle, L.)	ast)				2. Date of Dea	ith	3. Time of Death
П	Physici		Margaret Ann	Gardiner				Novemb	er 14, 200	06 1:40 A ^M
7	/Medic Examin		4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Death		4c. County of Dea	
			8995 Darley D	rive		La Pla	ata		Charle	S
	Funeral			Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y, Year) 9. Bi	rthplace (State or Foreign ountry)
	Director		212-34-5632	10 M 200 F	72 Yrs.			Nov. 1	4,1934 M	aryland
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or L	ocation				10d. Inside City Limits
	danyi f eho	៦	MD Charl	0.5	La Pla	+ 0				1 ☐ Yes 2 ☐ No
	28a-	ec.	10e. Street and Number	es	La Fla	10f. Zip Code			10g. Citizen of What C	ountry?
	3a or	Funeral Director	8995 Darley D	rive		2064	16		U.S.A.	
	death ms 2	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show says fujury or other treumatic event, the Medical Examinar must be maillist at ance.	<u>\$</u>	1 ☐ Never Married 2 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No	If Yes, specify Cuba 1 ☐ Yes 2 No	n, Mexican, Puerto Specify:	Rican, etc.)	Specify: Wh	
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7 8	Men Merke Marke	၉	Edwin J. Murp				Mary An			
Maryland	12 st h and 7 ie n		19a. Informant's Name/Relationship						r, City or Town, State,	, , ,
	Heelt Fm 2 ther		Hugh C. Gardi 20a. Method of Disposition	ner,III/r	20b. Place of Dispo				20c. Location - City o	
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Baltimore,	ertme ortani injury		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lig			natius C				
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	/Medical Examiner		resulting in dealiny	Due to (or as	a consequence of):					
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	nsit	i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
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Вох	eath cert ettendin for use	7	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		☐Ectopic pregnancy			23d. Date of de	alivery
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	To the Hospital or Attending Physicien: The law Within 24 hours eller death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) Certifying I 2 Medical Ex	Physicien: To the best eminer: On the basis o and manner st	f examination and/or in	th occurred at the time exestigation, in my of	ne, date and place, pinion, death occurr	and due to the cred at the time, d	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the To the Comp	Ň	29b. Signature and title of certifier			29c. License	number	2	29d. Date signed (Mon	th, Day, Year)
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State of Maryland / Department of Health and Mental Hygiene

38293 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 9, 2006 **Physician** 1:13 P M J. Gordon Everett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F 92 Washington, DC Yrs. 579-58-5535 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Iteme 23e or 28e-f ehow the Medical Examiner must be notified at MD Potomac Montgomery 1X Yes 2 □ No Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 8015 Cobble Creek Circle U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status within 72 hours after 1K∑Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 5+ Orthopedic Surgeon Medica1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Solvin W. Gordon Freida Weiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health ar Important: If Item 27 is any injury or other treu 10832 Barnwood Lane Potomac, MD 20854 Solvin W. Gordon - son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Clarksburg, MD Garden of Remembrance 11-12-06 4 □ Donation | 5 □ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Funeral Service Licensee 1091 Rockville Pike Rockville, MD 20852 C & CO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition vesulting in death) CONGESTIVE HEART **Physician** /Medical Due to (or as a consequence ol): Examiner PNEU MONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): anding physicien and use as the burial-transit Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? certificate 1 Yes 2- No 1 TYes 2FTNO Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ō within 24 hours a To the Funeral [Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 00057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, MD 9715 Medical Center Drive Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 16 Registrar

State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2006 GIASS MAN 15.30 **Physician** HARRIET /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 22, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 X F Director 120-03-9577 85 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ul Hygiene. other then "natural", or itema 23a or 28a-1 ehow vent, the Medical Examinar must be notified at X□Yes 2□No Directo Montgomery Village MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20130 Rothbury Lane #5203 20886 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 ☐ No Specify: Specify: Completed by White 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Legal/Medical/Government 12 Secretary pernit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if Item 27 is marked other ti any njury or other traumatic event, Ith 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Joseph Goldberg Sadie Kovitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20130 Rothbury Lane #5203 Montgomery Village MD Howard Glassman - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/14/06 Valhalla NY Sharon Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc. 1170 Rockville PikeRockville MD 20852 Approximate Interval Between Onset and Death 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ULMONARY MINU /Medical Due to (or as a consequence of): **Examiner** alvu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit 10 Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No. 9 Unknown 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) 4☐ Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2000 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 2 10 2 No this certificate 1 Yes 1 ☐ Yes : Atter this certification at the state of t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 27. Manner of Ceath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. efter death Director: A 6 Could not be determined within 24 hours efter de To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Winderey MD 59013 10 cause of death (Item 23a) (Type, Print) GLOJE PE 15825 New 31. Date filed (Month NO 32. Fegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23State of Maryland perpartment of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Sherron Davis Gaskins November 11. 2006 11:25A ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 25, 1 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 360-22-9567 1 □ M 2 □ X 77 Director 1929 Illinois Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Edgewater 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 56 Ridge Avenue 21037 USA permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, the Medical Exeminer must Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bert Alwyn Davis Kathryn Jessica Yonkers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherron G. Greulich / Daughter 1208 Chrisland Court, Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-16-06 Oak Hill Cemetery Washington, D.C. 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Mu 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Head Injuries with Complications Immediate Cause (Final **Physician** disease or condition resulting in death) HINOM /Medical Due to (or as a consequence of): Examiner DUIDAC Sequentially list conditions i any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine CETTIFE THE MEDICAL PROVIDED BY MEDICAL PROVID CIRKHOSIS Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9□Unknown or Attending Physician: The law requires that the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA, Cirrhosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1∐ Yes 2 rmed? 2 No certificate 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 Yes ZENO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation **Unknown**_M death. 09/01/2006 1 ☐ Yes 2 Tho Subject fell Director: 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Adult Day Care Center

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due in the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, 2525 Riva Road, Suite 100, Amapolis MD) 3 ☐ Suicide 4 Homicide within 24 hours after To the Funeral Dire the Hospital 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 NO 00 de D D 0061776 NOVEMBER 11,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD MEDICAL BRIAN C. WOLF 2001 PARKWAY ANNAPOLIS, MARYLAND, 21401 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year November 21,2006 **Physician** 2:50 PM Morton Irwin Goldman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/29/1926 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 11 M 2□ F 054-20-3187 79 New York Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 ☐ Yes 2 🕅 No Gathersburg Md Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 415 Russell Ave. #708 20877 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Sr. VP NUS Corp Nuclear Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Goldman Sadie Lapkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Russell Av. #708, Gathersberg, Md 20877 Marcia Goldman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/22/2006 King David Cemetery Falls Church, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5755 Castlewellan Dr. Jefferson Funeral Chapel Alexandria, VA 22315 mals complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Years Pulmonary Fibrosis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 Ĭ Probably 4 ☐ Unknown Be Completed Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2√√2 No Aspiration Pneumonia 24a. Was an autopsy performed? COPD certificate 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☑ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident after death filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 🖸 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58681 11/21/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Dr. J√dde Alexandér, MD Shady Grove Adventist Hospital Rockville, Md 20850 31. Dale filed (Month, Day, Year) 32 Registrar's Signature State Registrar DEC 0 1 2006

06-08989 Paul Gallagher

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Cert	tificate of	Death			Reg.		100	3023
Physicia edical Examir	ın/	1 Decedent's Name (First, Middle,Last) PAUL FERGUSON	GALLAGHER				, l	Date of Death Month D lovember 2			3. Time of Death 1838 hrs
		4a. Facility Name (if not institution, give st 1101C Heritage PI	reet and number)	ľ	4b. City, Town, Waldorf	or Location of	Death		4c. County o Charles	f Death	
Funeral Director		5. Social Security Number 6. Sex 214-08-5497 XXM Usual Residence of Decedent	7. Age (In yrs. la:	st birthday) Yrs		ear If Under	Min.	Date of Birth	,1971	Foreign	olace (State or
Maryland 28a-f show any d at once.	rector	10a. State 10b. County MARYLAND CHARLE 10e Street and Number		Town or Locati	10f Zip Code			109	Citizen of Wh		1 Yes 2 XXNo
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hard Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once	Completed by Funeral Dir	1101 C. HERITAGE 11. Marital Status 1 Never Married 2 Married 3 Widowed 4XX Divorced of 15. Decedent's Education (Specify only Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	2. Was Decedent Ever in U.S Armed Forces? Yes 2XXNo Yes, Give Year Dates.	If Y 1 1 16a. Deceden during m	2060 as Decedent of the se, specify Cub Yes 2XX at's Usual Occup ost of working to	dispanic Originan, Mexican, Formula, Mexican, Formula, Mexican, Formula, Mexican, Formula, Mexican, Me	nd of work se retired)	done 1	White Specify 6b Kind of Bus	- America , etc. WHI siness/Ind	dustry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Montal Hygiene Important: If item 27 is marked other than "natural". injury or other traumatic event, the Medical Examiner	To Be	19a Informant's Name/Relationship (Type BARBARA GALLAGHE 20a Method of Disposition 1 Burial 2 XX remation 3	Removal from State	2801	sition (Name of other place)	NEY LA	er or Rura	VALDOR ate	F, MARY 20c. Location -	n, State, 2 YLAN City or T	ID 20602 own, State
Baltin permit P Departme Importan injury or		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licenses	M004	78 3 N	Name and Addre	ess of Facility FUNE	RAL	SERVI	CE, P.	Α.	A, VA
Physician /Medical Examiner		23a. Part I. Enter the disease, or complicate failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Dilated cardious e to (or as a consequence of	yopathy	the mode of an	g such as car	diactor ré	spiratory arres	t,ShōcR, or hea	art	Approximate Interval Between Onset and Death
ed sit	Examiner	(Disease or injury that initiated events resulting in death) Last	e to (or as a consequence of	_							
P.O. Box 68760, shat the death certificate be executed gree by the attending physician and detached for use as the burial - transit	Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	AMENDED #23a,PII, 23c. If yes, outcome of pregr 1 Live birth 4 Pregnant at time of dea	2 Feath 5 Of	etal death ther (Specify)	3 Ectopic	pregnancy		23d. Date of Month	Da	y Year ye cause of death?
D 12. G	Completed by P	Part II. Other significant conditions of Diabetes mellitus	ontributing to death but not re	sulting in the i	underlying caus	e given in Pari		1 Yes 24a Was an autopsy perform	2 No 3 24b. V ped? d	Proba	bly 4 V Unknown opsy findings available impletion of cause of
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ing Pl After funera	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a Date of Injury (Month, Day Year)	28b. Time of	1	yes 2 !	No		w injury occurre		al Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the			(Specify) To the best of my knowleds	ge, death occu	rred at the time	, date and plac	ce, and du	or Town, Sta	(s) and manner	as starte	d.
To the within To the comple	Medical	one) Medical Examiner: Caracle and title of certifier Source and title of certifier	on the basis of examination and manner stated		29c Lice	ion, death occi ense number C.M.E.	urred at th		nd place, and d 29d. Date signe November	ed (Mont	h, Day, Year)
S Regis	tate	31 Date filed (Month, Day, Year)	nt Medical Examiner	111 Penr	Street, Ba	Itimore, ME	21201				

State of Maryland / Department of Health and Mental Hygieng [] [] [1 - State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 **Physician** 8:10 P M 23, Katherine Belle Hilton Nov. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Garrett Rural Route 455 Kempton Rd. Kempton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0.3/10/1929 9. Birthplace (State or Foreign Country) WV 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 77 236-54-9442 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. ant if frem 27 is marked other than "natural", or Items 23s or 28s-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ad other than "natural", or itema 23a or 28a-f ehow event, it a Modical Examinat must be notified at 1 Yes & No Director MD Garrett Kempton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21550 455 Kempton Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gertrude Perchum Michael Dragovich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James W. Hilton/son 1419 Key Pkwy Apt. A1 Frederick, MD 21702 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
eny injury or ot 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Omega Crematory 11/28/06 Morgantown, WV 21. Signature of Fur eral Service Licensee Hinkle Funeral Home P.O. Box 186 Davis, WV 26260 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary Chronic 15 years Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 🗌 Inpatient 3 DOA ို 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D27205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. 4th ST OAKLAND, MD θ E. SCHWALM 311 KARL 32 legistrar's Signature 31. Date filed (Month, Day, Year) State NOV 3 0 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND TILE 1 per PHYS 6661 1730/06 US
State of Maryland / Department of Health and Mental Hygiene 0 6

Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 9:15P M Myron L. Hale 19. 2006 MYRON HALE Nov. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1316 Stablersville Road Parkton Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 22, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 1927 Maryland 215-32-2416 79 Director Usual Residence of Decedent with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryler Depertment of Heelih end Mental Hyglene. Important: If Itam 27 is marked other than "natural", or Itama 23s or 28s-1 show any fujury or other traumatic avant, the Medical Examinat must be notified at once. 10a. State 1 ☐ Yes 2 🛣 No Director Parkton Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1316 Stablersville Road 21120 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ۵ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dairy Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Turnbaugh George Hale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1227 Stablersville Rd., Parkton, MD 21120 Sonia L. Blatchley/Friend Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition completely, crematory or other place)
Stablers United
Methodist Cemetery Nov. 22, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Parkton, MD ^{22. Name and Address of Facility}J.J. Hartenstein Mortuary, 24 Second St. New Freedom, PA 17349 21. Signature of Funeral Service Licenses Inc. Mil 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCUD VEARS Physician /Medical Due to (or as a consequence of): Examiner YSAKS HTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien end for use es the burlei-trensit The lew requires that the death certificate be executed YERRS IDDM Due to (or as a consequence of): Division of VItal Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No ţ deteched 9 Unknown 9 ☐ Unknown á 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.) nsuffeency 1 Yes 2 No 3 Probably 4 ⊉Unknown Rend peen 24a. Was an autopsy performed?
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Wind Klug MD D31295 11/21/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Buch Suite 4202 md 21204 N Charles St 6701 Wand 16/0852 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 3 0 2006 Registrar

06-08921 Wanda Hott Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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		 Facility Name (if not institution, gi 137 Pennsylvania Avenue)	4	o. City, Town, c Cumberlar		Death		Allega	nty of Death any	
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D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once	Funeral Director	137 PENNSYLV	12. Was Deceden			Decedent of H		n? (Specify	Yes or No-	US1		can Indian, Black,
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Baltimore, permit. Pages I an Department of He Important; If ite injury or other trees.	1	21. Sign = e of Funeral Service Li		1 .	22. Na	ame and Addre	ss of Facility	SCARI	PULL	UNEF	2AL H	OME, P.A.
	4	23a, f a. I. Enter the disease, of com	inlications that caused	the death D	i CO	VIRGIN	UNA AV	E., Cu	MBEF	Shock or	>, MD	Approximate Interval
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8760, ifficate be		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregna	·	al death 3	Ectopic p	oregnancy		23d. Date Monti	e of delivery h D	yay Year
Box 687 2 death certificate attending led for use as t	Physician	past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant a	t time of deat		er (Specify)						
O. Bc. that the desired by the a	훒	Part II. Other significant conditions	9OHKHOWH	th but not res	ultina in the ur	nderlying cause	e given in Part	:1.	23e. Did toba	acco use co	ontribute to	the cause of death?
Division of Vital Records, P.O. ra or Attending Physician: The law requires that tre safter death all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	اھ	Emphysema				, ,			1 🗸 Yes	2 No	3 Prob	ably 4 Unknown
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ivisior or Attend after death Director:	licat	2 Accident Investiga	28e Place of I	njury - At hom	ne, farm, stree	t, factory, office	building, etc.	28f.			umber or Ru	ral Route Number, City
Division Hospital or Attent 24 hours after death Funeral Director:	Certification:	Suicide 6 Could no determin			_				or Town, Sta	te)		
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	ledical (29a. Certifier (Check only one) 2 Medical Examin	cian: To the best of n	amination and								
To To	ğ	29b. Signature and title of certifier	and manner stated			29c. Licer	nse number		1	29d. Date s	signed (Mor	nth, Day, Year)
		Jash	Jeep n	M		0.0	C.M.E.			Novemb	per 24, 20	006
2		30. Name and address of person who Tasha Greenberg MD.	completed cause of Assistant Medic			Penn Street	t, Baltimore	e, MD 21	201			
Sta		31. Date filed (Month, Day, Year)	1	ar's Signature	4 /	ale)						
Registi	rar	NOV 3 0	2006 Mas	we B	· file	461						

State of Maryland / Department of Health and Mental Hygien 3830 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Betty Carol Hunt November 2006 20, 1842 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Hospital E1kton Cecil If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🏌 F Director 212-40-7946 64 May 14, 1942 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits , or iteme 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Directo Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Price Drive 21921 United States by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene. ant: if item 27 is marked other than "naturei", 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Her Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard Sweet Katherine Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Barrow/Daughter 2520 Biggs Highway, North East, Maryland 21901 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Elkton Cemetery 27, 2006 Elkton, Maryland 21. Signature of Funeral Service Licensee P.A. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician grade respiratory /Medical Due to (or as a consequence of) Examiner eumonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit or Attending Physician: The law requires that the death certificate be executed 20015 Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant iours after death.

nerel Director: After this certificete has been signed by the atter filled in by the funeral director, page 2 should be detached for i 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death
Natural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel C completely filled in Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D00060326 300 IMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) w Main St. Elka, MD 21921 absoyopnIND 23 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

			1 - For State Registrer	State of Mar	•	epartme Certifica			nd M		giene (06	38302
H	Physicia	20	1. Decedent's Name (First, Middle, Las							2. Date of Dea	Day .	Year	3. Time of Death
	/Medic		Monica Alice	Hegart	У					Novemb		2006	3:12 AM
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			Calvert Memorial 5. Social Security Number 6. Se		In yrs. last birth		rince er 1 Year	Frede		8. Date of Birth		alver	C place (State or Foreign
	Funeral Director			744 AFT F	96 Y	Month		Hours	Min.	Month, Day July 25	1910	Iowa	ntry)
			Usual Residence of Decedent							Jun 1 23	13.0	120.10	
	how how		10a. State 10b. County	1	Oc. City, Town	or Location						1	0d. Inside City Limits
	e Ma	ç	MD Calvert		Hunti	ngtown							1 Tyes 2X No
	라 5g 4	Dire	10e. Street and Number				ip Code				10g. Citizen o		ntry?
	eth v	Funeral Director	40 Cox Road	40.19-1	:		20639				U.S	ace - Americ	an Indian
	item item	ığ	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Even Armed Forces? 1 Yes 2 No	erin U.S.	If Yes, sp	ecent of Hi ecety Cuba	n, Mexican,	Puerto F	cify Yes or No- Rican, etc.)	В	lack, White,	etc.
5	hours effer deeth with the Maryland turel', or iteme 23e or 28e-f ehow al Examinar must be notified at	र्व	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2[X No	Specify:			Spec	eify: Wh:	ite
215-0036	s within 72 hours effer deeth with the Marylan jane. Jane. Then frature!, or iteme 23e or 28e-1 ehow the Medical Examinat must be notified at	Completed	15. Decedent's Ed	ucation	16a. [ecedent's Us	ual Occupa	ation	af wardsin	_	16b. Kind of	Business/In	dustry
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	ild be filed lental Hyg ked other ic event,	Be	17. Father's Name (First, Middle, Last)	Li D	_				's Name rence	(First, Middle,	_{Maiden Sum:} Jarie		ith
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စ်	ss 1 and 2 should of Health and Me item 27 is mark r other treumation		20a. Method of Disposition	reg, baagii	20b. Place of I		ame of			ate	20c. Location	n - City or To	own, State
e E	Pages ento nt: #		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		-	of Hea		-	1–17	-2006	Silver	Spri	ng, MD
Baitimore,	permit. Pages 1 Depertment of H importent: If ite eny injury or ott once.		21. Signature of Funeral Service Licens					s of Facility	,				
ñ	8959	-	LSTYN. K	utt		Ra	usch	Funera	al H	ome, PA	Owing	s, MD	20736
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	Physician		Immediate Cause (Final disease or condition	a	An	emine							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a							_		
	LAGIIIIICI	2	Sequentially list conditions,	b		7 ear		COUL	ev				
	ited nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,		trial		F. 6 mi	Hati	ala			
ŕ	ate be executed hysicien and the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a	consequence of):							
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B	ntifica ng ph as th	Jed	IF FEMALE:					-1-					
ROX	eath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2		3 □Ectopic	pregnancy	V				Date of delive	ary Day Year
9	at the dea by the at teched fo	Physician/Medical	t 🗆 Yes 2 🖫 No 9 🗀 Unknown	4∏Pregnant at tin 9☐ Unknown	ne of death	5 🗌 Other (specify)			<u> </u>		11011111	Day Tour
7.	The law requires that the death certificate be executed the hes been signed by the attending physicien and hage 2 should be deteched for use as the burial-transit		Part II. Other significant conditions co	entributing to death but	not resulting in	he underlying	cause give	en in Part I.		23e. Did to	bacco use co	ntribute to th	ne cause of death?
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င္ပ	w require been si should t	lete								24a. Was a	an 24b	. Were auto	psy findings available
Ř	sicien: The law s certificete hes t lirector, page 2 s	Completed								autop:	med?	prior to condeath? 1 Yes	psy findings available impletion of cause of
Ē		BeC	25. Was case referred to medical					26. Place of	of Death	(Check only or		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	25,00
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0	ding Ph h. After th funeral		27. Manner of Death t ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Y	/ear) 28b. Tii	me of ury	28c. Injury Work	at c?	2	8d. Describe h	ow infury occ	urred	
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Division of Vital Records,	P is c	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farr (Specify)	n, street, fact	ory, office		2	81. Location (S City or Tow		nber or Rura	I Route Number,
_	To the Hospital within 24 hours e To the Funerei Completely filled i		29a. Certifier 1 Certifying Phy	/sicien: To the best of	my knowledge	death occurre	d at the tim	ne, date and	place. a	nd due to the	ause(s) and	manner as e	tated.
	P Hoi	edicai	(Check only 2 Medical Exemone)	iner: On the basis of ea and manner state	xamination and	or investigation	on, in my or	pinion, death	occurre	d at the time, o	date and place	and due to	the cause(s)
	To the To the Complet	Me	29b. Signature and title of certifier			2	9c. License			- 2	29d. Date sign	ned (Month,	Day, Year)
	0,) Shel	MD			D	5029	70		11 ~	14-	-06
15	-10		30. Name and address of person who o	_					P	14 1	C 1		6-
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	Examin		4a. Facility Name	(If not institution, giv	e street and number)			4b. Ci	ly, Town, or	Location of Dea	th	40	. County of De	ath	
			PRIN	CE GEORGE	'S HOSPITA	L			CHE	VERLY			PRINCE	GEOR	GE'S
	Funeral Director		5. Social Security 578-94-7			e (In yrs. la 4	ast birthday) Yrs.	If Und Month	der 1 Year Is Days	If Under 24 Hrs Hours Min	. (Month, L	Birth Day, Year,	9. 8 1962 WA	irthplace (Country) SHINC	State or Foreign
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iệ t	or 2	Dire	10e. Street and No	umber				10f.	Zip Code			10g. Ci	tizen of What (Country?	
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het t	ad by detac		-		contributing to death be	ut not resul	Iting in the w	nderhin	a cause aive	no in Part I	23e Did	Ltobacco	use confribute	to the cau	se of death?
quires 1	n signe	ed by							, cause give	miliratti.		Yes 2	×	Probably	4 Unknown
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pl	2		30. Name and add	dress of person who	completed cause of d	eath (ftem	23a) (Type,	Print)	1 .	7/4		11/	19/0	- 4	
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		-	For State Registrar	State of	of Maryla		artment tificate			and M	lental Hyç	giene	'HUb	38304	
	* 5		1. Decedent's Name (First, Middle	, Last)							2. Date of Dea Month	ath Day	Year	3. Time of Death	
10.00	Physicia /Medic	al .	Helen			Hutt					November	16.	2006	9:30 P M	_
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au	d be ental ked o	To Be	Abraham Freund	,					Bar	bara	01af				
Maryland	shou ind M ind M	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	r or Rura	al Route Numbe	er, City o	r Town, State,	Zip Code)	_
	aith a aith a 27 is		William Ellis Hutt	/ Son		801	Mt. Pl	easan	t Driv	e Loo	ust Grove	e, Vi	rginia	22508	
ore,	of He of He fitem r oth		20a. Method of Disposition 1 ₩ Burial 2 □ Cremation			Place of Dispo cemetery, cres	sition (Nam	ne of			Date		cation - City or	Town, State	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hydrene. Important: if Item 27 is marked other than "naturel", or Iteme 23a or 28e-1 ehow any Injury or other traumatic event. Its Modical Executer man be collised at ODGs.		21. Signature Funeral Service	Licensee)	2:	Name and	d Addres	s of Facilit	Georg	ge P. Kala on Hill, N	es Fu	neral Hon	ne PA 745	
被			23a. Part1. Enter the disease or shock, or heart failure. List	complications that	caused the de	ath. Do not en	er the mode	ol dyin	g, such as	cardiac (or respiratory ar	rest,	201	Approximate Interval Between	
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	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	equence oi):									
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c	(or as a conse	equence of):									-
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687	ificate g phy as the			0.											_
Вох	death certifica e attending ph of for use as ti	M/C	IF FEMALE: 23b. Was decedent pregnant		itcome of preg birth 2 ☐ Fe		Ectopic pr	agnancy				1	23d. Date of de		
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<u>Р</u> .	at the 1 by th etach	Phy	9 Unknown				. 4 . 1. 2				22a Dida		an anatributa t	o the cause of death?	-
Division of Vital Records,	The law requires that the death certifica the has been signed by the attending pt bage 2 should be detached for use as it	ρ	Part II. Other significant condition OSTEOPOR	-	Jeath but not re	esulting in the L	naeriying c	ause give	en in Part I.	•	1 🗆 1			robably 4 Unknown	
00	w req	Completed									24a. Was		24b. Were a	utopsy lindings available	
æ	hysician: The law his certificate has t I director, page 2 s	E									autop perfo 1 Tes	rmed? 2X No	death?	completion of cause of	
ita		Be C	25. Was case referred to medical examiner?						26. Place	of Deat	h (Check only o				
<u>></u>	Physician: this certific	To	1 ☐ Yes 2 No			☐ ER/Outpatie					me 5 ☐ Resid			acify)	
D C	ing P	on:	27. Manner of Death 1 Natural 5 ☐ Pendin		ol Injury nth, Day Year)	28b. Time of Injury		8c. Injun Worl			28d. Describe I	now injur	y occurred		
sio	Attending in death. • ctor: After by the fune	cat	2 Accident investig	not be	o of Injune - At	home, farm, st	M factor		Yes 2 🗆		28f Location (Street an	d Number or B	tural Route Number,	_
$\overline{\leq}$	or Arratter of Direct	Certification:	4 Homicide determ	nined 289. Flat	ding, etc. (Spe	cify)	reet, ractory	, once			City or Tox	vn, State)	arar rioute ivamoer,	
_	To the Hospital or Attending Physical thin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.		29a. Certifier Certifyir	ng Physician: To th	ne best of my k	nowledge, dea	h occurred	at the tin	ne, date an	nd place,	and due to the	cause(s)	and manner a	s stated.	
	HO HO HO HO HO FUI	edical	(Check only 2 Medical one)	Exeminer: On the and ma	basis of exami nner stated.	nation and/or in	vestigation	in my o	pinion, dea	ith occur	red at the time,	date and	place, and due	e to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifie	, 11			290	Licens	number			29d. Dat	te signed (Mont	th, Day, Year)	
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1	-(6)		30. Name and address of person			em 23a) (Type ine Centa	,	7 1.1-	Idorf	Mee	/land 2060	72			
			Louis V. Kauffin					, Wa	HUULL,	rary	Lailu 200	J 4			
4	Regist	ate rar	NOV 2 0 20	06 Bere	D.	nature	V								
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	-	For State Registrar	State of M	arylan		artment rtificate				ental Hy	ygien Reg. N	$Z \coprod \coprod$	6	38305
Physicia		1. Decedent's Name <i>(First, Middle, La</i> Barbara Jea	1	er					2	2. Date of D Month Novemb	eath	av	Year NO6	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution, giv 5607 Woodville Ro		1		4b. City, T				NO V CIII	4	c. County o	f Death	
Funeral Director		210-32-3333	C	90 (In yrs. 59	last birthday) Yrs.	If Under 1 Months	Year Days	If Under: Hours	Min.					
nours after death with the Maryland lural, or Items 23a or 28a-f show al Examilier roust be nutified at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Frederic	ek		y, Town or Lo								1	10d. Inside City Limits
23a or 28	al Ulrector	10e. Street and Number 5607 Woodville Ro	oad		•	10f. Zip (10g. C	itizen of WI	hat Cour	ntry?
tural', or items 23a or	Dy Fur	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		1	Was Decede f Yes, specif		spanic Orig n, Mexican Specify:	gin? (Specit n, Puerto Ric	fy Yes or N can, etc.)		14. Race	, White,	
then "na the Modic	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12) 10		5+)	(Give life. L	lent's Usual kind of work DO NOT use Priver	done di retired)	urina most	t of working		Mo	Kind of Bus ntgom blic	ery	County
e veri	lo Be	17. Father's Name (First, Middle, Last) Leland Herman Ric	ketts					Dori	s Mar	garet	Emb	ery	,	
am 27 ther to	-	19a. Informant's Name/Relationship (Vernon L. Holsing 20a. Method of Disposition			19b. Mailin d 560 lace of Dispos		dvi1	lle R	oad, l	Mount	Air	у, Ма	ry1a	and 21771
rtant: If		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	y)	a	klawn 1	natory or oth Memori	al l	Park				ocation - C	•	wn, State Maryland
any i		23a. Part1. Enter the disease, or complete, or heart failure. List only	m. De	88		Name and Molesw 20401 or the mode	ort	h-Wil	liams	Fune amasc	ral us,	Home Mary]	P.A and	20872 Approximate
physician and street st		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as c. Due to (or as	ANC a consequ	ed n	ihr on-s	m9/1	/ Cell	1 6	weg_	Car	r C.L.	(Interval Between Onset and Death I much the own the
be detached for use as	Iyaicidining	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic prec Other (spec						23d. Date Month		ry Day Year
		Part II. Other significant conditions o	ontributing to death b	ut not resu	ulting in the un	derlying cau	se giver	n in Part I.		23e. Did 1	/			e cause of death?
page 2										24a. Was auto perfo 1 🗆 Yes		24b. We pride dea	ere autop or to con ath?] Yes	osy findings available inpletion of cause of
his certification of director	ב	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatie	ent 2 🗀 E	ER/Outpatient	3□ DQA	Other		of Death (C			6 □Other	/Snacihi	
After t funera		27. Manner of Death 1 1	28a. Date of Injui (Month, Day	ry	28b. Time of Injury		:. Injury a Work? 1 🗆 Ye		28d	I. Describe)
To the Funeral Director: completely filled in by the Medical Certifical		4 Homicide determined	building, etc	c. (Specify						City or To	wn, State	9)		Route Number,
To the Funeral Completely filled		one)	ysician: To the best on hiner: On the basis of and manner sta	examinati	ion and/or inv	estigation, in	ту ори	nion, death	place, and h occurred a	due to the at the time,	date and	d place, and	d due to	the cause(s)
COU		29b. Signature and title of certifier		(2	D4	186					te signed (/ ember		
		30. Name and address of person who d Kanan H. Hudhud,	M.D. 46E	3 Tho	mas Jo		Dri	ve,	Frede	rick,	Mar	yland	1 21	702
State		31. Date filed (Month, Day, Year)	OUR 32. Pegistra	ar's Signat	ure H									

State of Maryland / Department of Health and Mental Hygien@ [] 38306 1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** RUTH MARIE HUMPHRIES NOV. 2006 6:00 A 15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner KENT CHESTERTOWN MAGNOLIA HALL If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 👿 F Yrs Director 579-20-5837 89 VIRGINIA JULY 2, 1917 Usual Residence of Decedent the Maryland 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Mudical Example invalue to notified at 1 XYes 2 No Director MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 MORGNEC RD 21620 USA death by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene important: if them 27 is marked other than "natural; or iten eny injury or other traumatic event, the Mudical Eventering Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 27 No Specify: WHITE Specify: 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 -0-FACTORY WORKER GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN DAVID SNYDER DESSIE MAE PRICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIE MAE SCHOENIAN/ DAUGHTER 14960 COLLIER RD 2091, NAPLES, FL 34119 20b. Place of Disposition (Name of 20a Method of Disposition 20c. Location - City or Town, State E.U.B. (COVERSTONE) 1 XBurial 2 Cremation 3 Removal from State 11-18-2006 SHENANDOAH, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License FELLOWS, HELFENBÉIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Alzheimer Immediate Cause (Final Dementia **Physician** 5 49 eavs disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, π any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by areliora cular 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 2 No 1 Yes the Hospitel or Attending Physician: After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 1 Solatural 2 Accident 5 Pending 1 Yes 2 No death. investigation 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1017036 m. J? 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 516 Washington Are. Chestatom Md 21620

Registrar

31. Date filed (Month, Day, Year)

Susin K. Ross M.D.

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrat Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Marshall Eugene November 20 2006 8:17 A 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Williamsport 14731 Clear Spring Road Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Months 1XXM 2 F 214-34-0933 Sept.15,1935 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14731 Clear Spring Rd. 21795 USA 12. Was Decedent Ever in U.S. Armed Forces?

**TXXY'es 2 □ No 195 of Yes, Give Year or Dates: 1950 Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Btack, White, etc. 1 Never Married Married 1957-1 ☐ Yes XXNo Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Process Assistant Concrete Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marshall Ezra Milbrey Emma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryann M. Hurd - Wife 14731 Clear Spring Rd. Williamsport, MD 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Paul's Cemetery | Nov.22,2006 | Clear Spring, Maryland

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othe sry injury or other traumatic avent, once.

Physician

/Medical

Examiner

Funeral

Director

"nstural", or itsme 23a or 28a-f show

Directo

Funeral

Completed by

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the attending physician and the of for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician/Medical

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Completed

Be

Certification: To

Medical

been sig

this certificate has page 2

After this certific funeral director,

within 24 hours after deam.

To the Funeral Director: After the funeral in by the funeral management of the funeral manage

cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, le cause on each line.	Approximate Interval Between Onset and Death
Left sided Congistive Heat Foilure.	4-6 hours
Due to (or as a consequence of):	
Chronic Obstructive Pulmonay Distre.	3 10 years
Due to (or as a consequence of):	
Due to (or as a consequence of):	
2a H von automa of programs	

Osbomned Fourment Batilithome, P.A.

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Illnknown

21. Signature of Funeral Services

Immediate Cause (Final disease or condition resulting in death)

Parti: Enter the disease, or complishock, or heart failure. List only or

1 ☐ Live birth 2 Fetal death 4 ☐ Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month

Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 20 No 1 Yes 26. Place of Death (Check only one)

425 S. Conococheague St. Williamsport, MD 21795

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐-No

25. Was case referred to medical examiner? 1 ☐ Yes 2 Ø No 27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

Hospital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

 Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending

investigation 6 Could not be determined

> 29c. License number 0-0056413

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WH-5+1

aniai 31. Date filed (Month, Day, Year)

1138 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Arvella Hafer 1- For State Certificate of Death Reg No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 16, 2006 0505 hrs Medical Examiner Arvella Ruth Hafer 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Route 63 South-mile 3 Sharpsburg Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Maryland oreign Months Days Hours Director Country) M 44 22, 1961 212-82-4919 2XXF Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No 28a-f show Washington Sharpsburg Maryland hours after death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f, Zip Code or items 23a or 28a-must be notified at 21782 USA 16643 Shaffer Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 14. Race - American Indian, Black, 11. Marital Status 12 Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married Yes Yes 2 No specify: 3 X Widowed 4 Divorced If Yes, Give Year Specify White permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hyggiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Polyethelene Tank Manu. Laborer 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Giffin Doris Louise Thompson 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ Steven Taylor - Son 16643 Shaffer Rd. Sharpsburg, Maryland 21782 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State Bakersville Cemetery |Nov.21,200d Boonsboro, Maryland 4 Denation 5 Other Specify OS DOF MEAGFRENCE FOR BY Home, P.A. 21. Signature of Funer 425 S. Conococheague St. Williamsport, Maryland Approximate Interval 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Between Onset and /Medical Death a. Head Injuries Immediate Cause (Final disease **⊆**xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examine cause Enter Underlying Cause (Disease or injury that is illiated events resulting in death). Last Due to (or as a consequence of) attending physician and or use as the burial - transi Physician/Medical UNPENDED AMENDED of Vital Records, P.O. Box 68760 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 V No 3 Probably 4 Unknown Completed this certificate has been s I director, page 2 should 24a. Was an 24b. Were autopsy findings available autonsv prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Be Other₄ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other Scene ို 1 🗸 Yes 2 No 28a. Date of Injury FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Driver auto fixed object collision within 24 hours and To the Funeral Director: A FOUND: Division Natural Yes 2 V No 5 Pending Nov 16, 2006 0450 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) Route 63 SB at 3 mile marker, Washington County, MD determined (Specify) Major Road / Highway 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifier O.C.M.E. November 16, 2006 30. Name and address of person who completed cause of death (Item 23a) 311-5 Susan Hogan MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	38311
State of Maryland / Department of Health and Mental Hygiene U U U	30311
Certificate of Death Reg. No.	

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Maryland	a-f ahow	Illied at		ctor

		•	For State Registrar		Oldio of	mary tar	Ce	rtificate			,	Reg. No.		
	· · ·		1. Decedent's Name (Fire	st, Middle, Las	t)						2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici Medic		James	В Н	untley						Nov	08	2006	4:40 P ^M
54	Examin		4a. Facility Name (If not	institution, give	street and num	ber)	-	4b. City, Tov	wn, or L	ocation of Death		4c. Co	ounty of Death	
		1" Na.	Washington	Adven	tist Ho	snital		Tak		Park, M			tgomery	
	Funeral		Washingtor 5. Social Security Number		X M 2□F			If Under 1 Y Months D	ear ays	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	Year)	9. Birthp Coun	ace (State or Foreign try)
. 3	Director		420-22-0948)	* ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	84	Yrs.				Oct 18,	1922	Besse	mer, Al
	and w	-	Usual Residence of Deci 10a. State 10b	. County		10c. Cit	y, Town or Lo	ocation	_				1	Od. tnside City Limits
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	r 28a-f ahow	Director	MD PY	ince G	eorge		Hyatts	10f. Zip Co	ode			10g. Citizer	n of What Coun	try?
	with the or											LIC A		
	death with the Maryland oma 23a or 28a-f ahow ir must be notified at	Funerai	4922 LaSall	e Road	12. Was Dece	dent Ever in U	.S. 13.	Was Deceden	1782 t of His	panic Origin? (Sp	pecify Yes or No- Rican, etc.)	14.	Race - Americ	
(0	or iter	Fur	1 Never Married	2 Married	Armed For	ces? 2 No. 194	1				o Hican, etc.)		Black, White,	
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21215-0036	72 hours after "natural", or its	Completed	15. (Specify or	Decedent's Ed	lucation de completed)		(Give	dent's Usual C	done du	ion iring most of work	king	16b. Kind	of Business/Inc	lustry
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<u>₹</u>	should be filed withir and Mental Hygiene. marked other than imatic avant, the Mental avant, the Mental avant.	2	19a. Informant's Name/I		Tuna Printl		19h Maili	na Address /S	treet an	Ethel	Peterse	n City or Ti	own State Zin	Code
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Baltimore,	permit. Pages 1 Department of I Important: If its any injury or ot		1 ☐ Burial 2 ☑ Cre 4 ☐ Donation 5 ☐			tata	-	matory or other Crema			18,200	5 R-	iverdal	□ MD
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Division of Vital Records,		Certification:	4 Homicide	determined	280. Place	of Injury - At h ig, etc. (Speci	iome, farm, st fy)	reet, factory, o	office	1	City or Tox	street and r vn, State)	Number or Hura	I Route Number,
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	To the Hospital or within 24 hours after to the Funeral Direction of th	Me	29b. Signature and title	of certifier		2	- /	29c. 1	1000SB	number		29d. Date s	signed (Month,	Day, Year)
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Carlos H. Escobar 06-08782

Please Type or Print in Black Indelible Ink

UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No. Registrar I. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 18, 2006 0652 hrs Medical Examiner Carlos Henriquez - Escobar 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreign E 1 Cosaivador Months Davs Hours 1989 17 Aug. 4, Director $1^{|X|}M$ N/A 2 Usual Residence of Decedent ĭny 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show d at once. Temple Hills 1 X Yes 2 No Maryland Prince Georges permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In firem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 Republic of El Salvador 2023 Gaither Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Yes 1 x Yes 2 No specify: Salvadorian If Yes, Give Year Specify: Hispanic 3 Widowed 4 Divorced ≥ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Private Laborer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Delmy Henriquez Adrian Escobar 19a Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ 2023 Gaither Street Temple Hills, Md. 20748 Delmy Henriquez / Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 Burial 2 Cremation 3 X Removal from State 11/30/2006 El Paraiso El Salvador Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Alexander S. Pope Funeral Homes, P. 5538 Mariboro Pike/Forestville, Md. MOIUS 20747 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** failure. List only one cause on each Between Onset and /Medical Death Complications of head injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine couse: Enter Uniderlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) · transit and Physician/Medical X UNPENDED the attending physician led for use as the burial -AMENDED 2862, 12/27/06 TT #23a.27.28a-f Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Ectopic pregnancy Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for g Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 V Unknown certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? page Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi completely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 DOA 1 🗸 Yes 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28d. Describe how injury occurred Certification: Natural 1 Yes 2 No 5 Pending Fnd 11/12/2006 Fnd 7:05 pm unknown 2 Accident Investigation 28f. Location (Street and Number of Rural Route Number, City, or Town, State) 24th Avenue & Gaither St 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be or Town, State) 3 Suicide determined (Specify) found on local street Suitland, 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only one) 2 / Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d Date signed (Month, Day, Year) 29c License number O.C.M.E November 19, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Carol Allan, MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) **NOV 2 7 2006** Registrar's Signature State Registrar

Physic	an	Decedent's Name (First, Middle, La: Doris	st) Nadi	ne	Harshm	an		2. Date of Deat Novembe		. 2005	3. Time of Death 10:15 Pm M	
/Medi	cal	4a. Facility Name (If not institution, giv					Location of Dea			ounty of Deat		
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anyler ehow	<u>_</u>	10a. State 10b. County Maryland Carro	11	10c. City, Towr	Westmin	ctor					10d. Inside City Limits 1 XYes 2 No	
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 26 2006 **Physician** Rhoda Horst Hege 9:00 A. M /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Mennonite Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year July 23 19 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 💢 F 96 219-68-0613 Yrs. Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State r than "natural", or Items 23a or 28a-f show the Madical Expedient must be notified at 1 ☐ Yes 2 No Hagerstown Director MD. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21740 13436 Maugansville Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Specify: White ≥ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 should be fi h and Mental F 7 is marked otl Jacob Henry Risser Anna Horst 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health at Important: If item 27 is any injury or othar trau once. Sharon Richards/Daughter 15930 Hosta Dr. Hagerstown, MD. 21740 Baltimore, 20b. Place of Disposition (Name of commetery, crematory or other place)
Mt. Olive Mennonite
Church Cemetery 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/1/06 Maugansville, MD. * 4 ☐ Donation 5 ☐ Other (Specify) Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Fa. 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause [Lisease or injury] Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 4 Pregnant at time of death been signed by the a should be detached f o. 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the upderlying cause given in Part I. Completed by Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes certificate 2 No of Vital After this certification funeral director, p Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🗖 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident Division 5 Pending s efter death. 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō within 24 hours or To the Funaral To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number DOO 63233 husos 30. Name and a ress of person who completed cause of death (Item 23a) (Type. Print)
Shahid Mahmood MD. 580 Northern Ave. Hagerstown, Md. 21742 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature State Begins B. Species Registrar

DHMH 17 Rev 1/2001

ORIGINAL

/Medic	an	Decedent's Name (First, Middle, Last) .To	ohn Frankli	n Hugh	es		2. Date of Deat Month November	Day Yes	3: 10 P.	
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uneral irector		5. Social Security Number 6. Sex 508-18-3705	7. Age (In yr.	rs. last birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 2	9. (1924 W	Birthplace (State or Fore Country) yoming	
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teract is marked other than "naturel", or items 23a or 28s-1 ehov other treumstic event, if a Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: WW.		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black, W	merican Indian, hite, etc. White	
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euma euma		19a. Informant's Name/Relationship (Ty			ng Address (Street a				e, Zip Code)	
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Important: if item 27 is any njury or other tre		20a. Method of Disposition 1	lamoval from State		matory or other place 11 Cemete		2/06	Creencas		
any nice		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zimmerman And Son Funeral Home Industrial 45 S. Carlisle St. Greencastle, P.								
/sician ledical aminer	Physician/Medical Examiner	xamlner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last	Due to (or as a cons	equence of):	TH	îss Suffi	e itni uy		Interval Between
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П	Physici /Medi		Joseph N. Irvin							N	Month Iovembe	er 1	1, 2006		40 A M
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	Funeral		5. Social Security Number 6. Se	x 7. Ag] M 2 ☐ F	ge (In yrs. las	st birthday) Yrs.	If Under 1 Y	/ear Days	If Under 2 Hours	Min. 8	. Date of Birt (Month, Day	(, Year)		Country)	tate or Foreign
	Director		Usual Residence of Decedent		78	115.					Jan. 1	.4,	1928	V ir g i n	ıia
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Baltimore,	permit. Pages 1 Department of H Important: If Its ony Injury or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F		сел	netery, crer	sition (Name on matory or other	r place		Date			cation - City o		te
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State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 38316 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 4:16 P 11, Nov 2006 William A. Johnson, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death Examiner Clinton, Maryland Prince Georges Southern Maryland Hospital 7. Age (In yrs. last birthday)
Whonths Days Hours Min.
Yrs.

1 If Under 1 Year If Under 24 Hrs. About 1 Hours Min.
Whonths Days Hours Min.
Whost Dec 5, 1938 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Kittrell, NC Director 243-46-5259 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deperment of Heelth and Mental Hyglene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other trsumatic event, the Medical Example in multipe coulling a once. District Heights 1X Yes 2 No Maryland Prince Georges Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20747 United States 7111 Gateway Blvd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14D Yes 2 □ No If Yes, Give Year or Dates:1960 -68 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 K No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Independent Trucker Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Somoria Gill William A. Johnson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 396 Fern Lane, Henderson, NC 27537 Jacqueline Williams (Daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 11/16/2006 Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Puneral Service License POPE FUNERALF AHOMES, P.A. 5538 Marlboro Pike, Forestville, MD arry ammons 6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ettending physicien and for use as the buriel-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 90 1 Yes 2 No 3 Probably 4 Unknown LUNG CANCER Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 Yes 2 No 1 Yes 2 No or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Matural 5 Pending after death. If Director: Al t Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a
To the Funeral I
completely filled 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. 29c. License numbe JODRIC NOVEMBER 13, 2006 D40324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURRATTS ROAD, CLINTON, MARYLAND 20735

DHMH 17 Rev 1/2001

State

Registrar

TERRY JODRIE, M.D.

31. Date filed (Month, Day, Year,

NOV 2 0 2006

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

7503

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#24a, per VERB., G861, TI / 30/06, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Linda Marie Kreitz /Medical 21 November 2006 9:21 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 🕅 F Yrs Director 212-62-2562 May 4,1953 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show ral", or Items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2K No Md. Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16037 Kelbaugh Rd. 21788 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. within 72 hours after Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the filed with.

Hygiene.

the than "n.

the Mar Elementary/Secondary (0-12) College (1-4or 5+) 12 School Bus Driver Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fil of Health and Mental H fitem 27 Is marked oth Be Carroll C. Topper 2 other traumatic Gladys M. Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16037 Kelbaugh Rd. Thurmont, Md. 21788 Michael Kreitz (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ' permit. Pages 1
Department of H
Important: If ite
any Injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Nov. 24, Smithsburg Crematory 4 □ Donation 5 □ Other (Specify) Smithsburg, Md. 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 MO1414 **WAVIS** 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 ☐ Other (specify) ed by the detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, δ Masanco been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy performed? certificate 1∐ Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation Injury within 24 hours after death. To the Funeral Director: 1 Yes 2 No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number D44164 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10

State Registrar

31. Date filed (Month, Day, Year) NOV 3 0 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
46 B Manas Johnson Drue, FREDERICK, MD 21702 egistrar's Signature

HEGAZI, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day U Lydar Month **JOHNNIE** KEY JR. NOVEMBER 14, 2006 12:16 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince Georges Suitland 4785 Huron Ave. Apt. 14 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year North, Day, Year Dec. 23, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**X**M 2□F 1947 578-60-2023 58 Georgia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Suitland Maryland Prince Georges 1 AYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4785 Huron Ave. Apt. 14 20746 United States 12. Was Decedent Ever in U.S.
Argied Forces? I.U. 6
1 Yes 2 No. 69
If Yes, Give VIETNAM
Year or Dates: ERA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☑ No Specify. 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Laura Unknown John Key 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7214 Westchester Dr. Temple Hills, Md. <u> Johnathon Key / Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/21/2006 Cheltenham, Md. Maryland Veterans 22. Name and Address of Facility
Alexander S. Pope Funeral Homes, P.A.
5538 Mariboro Pike/Forestville, Md. 20747 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 101085 Approximate Interval Between Onset and Death Immediate Cause (Final HYPOGLYCEMIA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【★No 24a. Was an performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28h. Time of 28d. Describe how injury occurred (Month, Day Year) 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner

and

attending physician

After

To the Hospital within 24 hours a To the Funeral I

Physician

/Medical

Examiner

Director

by Funeral

Be Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Maryland 21215-0036

Baltimore,

or Attending Physician; The law requires that the death certificate be executed

Box 68760.

Division or Vital Records, P.O.

Examiner Physician/Medical ð Completed Be P funeral Certification: s after dean. filled in by Medical

IF FEMALE 9 🗌 Unknown

4 Homicide

examiner? 1 AYes 2 No 27. Manner of Death

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

#D0031099

29d. Date signed (Month, Day, Year) NOVEMBER 14, 2006

30. Name and address of person who completed puse of death (N m 23a) (Type, Print)

ERIC NYLEN, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422

State Registrar 31. Date filed (Month, Day, Year, NOV 2 0 2006

29b. Signature and title of certifier



		1 - For State Registrar	State of Maryla		artment of I rtificate of			gienez 0 0	6 38319
Physic	ion	1. Decedent's Name (First, Middle, Li	ist)				2. Date of Dea Month		3. Time of Death
Physic /Med		DORSEY	FRANCIS	KNIGH	r, JR.		NOV.	17, Day 2006 Ye	12:00 PM
Exam	iner	4a. Facility Name (If not institution, gi				or Location of De	ath	4c. County of E	
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Funera Director			1□ M 2□ F	75 Yrs.	Months Days	Hours Mi		1931 9.	Birthplace (State or Foreign Country)
		Usual Residence of Decedent	Α	7.5			THE ICE	, 1731	V21
nylan how		10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
Be-f	cto	VA ACCOMAC	CK 1	HALLWOOI					1 ☐ Yes 2 ☐ No
with th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
eath y	Funerai	24487 SAVANNAH	ROAD 12. Was Decedent Ever in	nHC 12	2335		(Casaita Vas andia	USA	kmerican Indian.
ter d	F	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces?	10.5.	If Yes, specify Cub	an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)		/hite, etc.
urs al	5	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specity:		Specify:	WHITE
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ygier th		17. Father's Name (First, Middle, Las	4)	AUT	COMOTIVE		(27)	AUTOMOT	IVE
i be fi	Be	DORSEY F. KNIGHT				MAMIE	ame (First, Middle,	Maiden Sumame)	
thoutch Mark	2	19a. Informant's Name/Relationship		19h Maili	ing Address (Street			r, City or Town, Stat	e Zin Code)
inc, intally latter Z IZ IZ COOOO s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, Item 27 is marked other than "naturel", or Itema 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at		DORSEY F. KNIGHT						CITY, MD	,
S 1 a		20a. Method of Disposition	20	b. Place of Dispe			Date	20c. Location - City	
Pages nent of nnt: If it		Marial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec	Removal from State		CEMETER		20/06	OAK HALL.	. VA
permit. Pages 1 and 2 Depertment of Health a Importent: If Item 27 is eny Injury or other trai		21. Signature of Funeral Service Lice						UNERAL HO	
2015		Link 4.5	CARL U. THOR					LEY, VA 23	
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/Medical Examiner		resulting in death)	Due to (or as a con-	sequence of):					
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nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		30,7					
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ires that the death certificate be executed signed by the attending physicien end dbe detached for use as the burial-transit	dicai		d						
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ath ce ttendi	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	etal death 3[⊒Ectopic pregnanc	/		23d. Date of Month	delivery Day Year
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To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying P	hysician: To the best of my	knowledge deat	h occurred at the til	me, date and nia	ce, and due to the o	ause(s) and manner	as stated
Ho: Fur letely	Medical	(Check only 2 Medical Exa	miner: On the basis of exam and manner stated.	nination and/or in	vestigation, in my o	pinion, death oc	curred at the time, d	ate and place, and	due to the cause(s)
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0		30. Name and address of person who	completed cause of death	Hem 23a) (Type,	Print)	r 1	0.0	/	
4		1654-Mark	J St.; 7	ocon	oke,	MI)	21851		
Si Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Si	griature #	hack .				

	1 - For State Registrar	State of Maryland		rtment of He			giene	6 38320
Physician	Decedent's Name (First, Middle, Last) Wing and a Man, Wang.					2. Date of Dea Month	ath Day	3. Time of Death
/Medical Examiner	Virginia Mae Knaj	street and number)		4b. City, Town, or	Λ	Nevemb	4c. County of Some	Death
Funeral Director	MANGKN MANG 5. Social Security Number 6. Sec		ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birtl (Month, Day 11/30/	h v, Year)	Birthplace (State or Foreign Country)
D	134-03-4469 Usual Residence of Decedent 10a. State 10b. County		r, Town or Loc	eation		11/30/	1910	New York 10d. Inside City Limits
death with the Maryland me 23s or 28s-f show rmust be routiled at	MD Somerses	Pri	ncess				10s Citizen of Wh	1 XYes 2 □ No
th with It	11974 Edgehill Te	errace		10f. Zip Code 21853	3		10g. Citizen of Wh	at Country?
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SUPPOSE 121215-0036 led within 72 hours a yajeine yajeine yajeine yajeine yajeine yajeine yajeine yajeine yajeine yajeine yajeine	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give I life. D	O NOT use retired)	tion uring most of workin	ig .	16b. Kind of Busi	ness/Industry
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Box 68760, eath certificate be evaluated attending physicien for use as the burian cian/Medical Ecian/Medical E	IF FEMALE:	. CHF.						
P.O. Box 66 hat the death certifics d by the attending pt telached for use as it Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknowh	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date Monti	
cords, P.O. I w requires that the de been signed by the a should be detached I	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the un	derlying cause give	n in Part I.	23e. Did to		ute to the cause of death? Probebly 4 Unknown
il Record The law requir page 2 should						24a. Was autop perfor 1 Yes	rmed? pri	ere autopsy findings available or to completion of cause of ath?
Division of Vital Records, P.O. Box 687 tall or Attending Physicien: The law requires that the death certificate is after death. el Director: After this certificate has been signed by the attending physical by the funeral director, page 2 should be detached for use as the Certification: To Be Completed by Physician/Medic.	25. Was case referred to medical examinar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		ER/Outpatien 28b. Time of Injury	28c. Injury Work M 1 \(\sum Y	at 2 No	ne 5 Resid	lence 6 ⊡Other low injury occurred	
	4 Homicide determined	building, etc. (Specify	′)			City or Tow	vn, State)	or Rural Route Number,
Divi To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by Medical Certifit	(Check only one) 2 Medical Exami 29b. Signature and title of certifier	ner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my op 29c. License	number	d at the time,	date and place, an 29d. Date signed (Month, Day, Year)
	30 Name and address of pers in who co	ompleted cause of death (Item	23a) (Type, I		63991		11-20-	· 1 11
State	31. Date filed (Month, Day, Year)	32. Registrar's Signal	IVID.	11414	telephi	y em	ace tru	ress Muly
Registrar	NOV 2 2 2	AAS Marie	ORIGIN	Al				

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrat Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** Goldie E. Kidwiler NOVEMBER 14, 2006 5:20A.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reeder's Memorial Home Boonesboro Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Pay, Year) 3/15/1939 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 67 Yrs. Director 236581569 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. Counts 10d. Inside City Limits 77 is marked other than "neturel", or iteme 23e or 28e-f show treumstic event, the Modical Examinar must be notified at treumstic event, the Modical Examinar must be notified at Director 1 Yes 2 No Washington Sharpsburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3702 Lime Kiln Rd 21782 USA deeth v Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2€ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peges 1 and 2 should be nent of Health and Mentel Henry Woods T.ee Lookingbill ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Kidwiler 3702 Lime Kiln Rd. Sharpsburg, MD 21782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Peges Depertment of I Important: If Its any Injury or o XXBurial 2 Cremation 3 Removal from State Rosedale Cemetery 11/18/06 Martinsburg, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Servin Licron ee 22. Name and Address of Facility Rosedale Funeral Home 917 Cemetery Rd. Martinsburg, WV 25404 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heert failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition Onset and Death **Physician** relateable resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit physicien and resulting in death) Last Due to (or as a consequence of) Physician/Medical the the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificete 1 ☐ Yes 2 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 ☐ Yes 2 ☑ No Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 032518 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21 WYAND DRIVE, KEEDYSVILLE, MARYLAND 21756 (301) 432-2222 DR. ROBERT GUEDENET, 31. Date filed (Month, Day, Year) NOV 20 2006 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

land 21215-0036

Baltimore, Maryl

Division of Vital Records, P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygiene 2006 For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 5:00A M NOVEMBER 16,2006 DONALD $_{
m LEE}$ LOFTIS /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CHARLES 5925 WINTERS DRIVE LA PLATA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Yrs. 69 13,1937 WASH.,DC Director 577-48-4478 Usual Residence of Decedent 10d. Inside City Limits the Manyland 10c. City. Town or Location 10a. State 10b County r than "naturel", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 X No MARYLAND CHARLES LA PLATA Direct 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 5925 WINTERS DRIVE 20646 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1954-1957 □ Yes ★★No Specify: within 72 hours after Baltimore, Maryland 21215-0036 Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) PEPCO s 1 and 2 should be filed w if Health and Mental Hygier Item 27 is marked other th other traumatic event, the 12 AUTO MECHANIC 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VIRGINIA DARE RAUDBUSH WILLIAM WARD LOFTIS, JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
eny injury or other trau 5925 WINTERS DRIVE, LA PLATA, MARYLAND 20646 JOANNE LOFTIS-SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS CEM. 11-21-06CHELTENHAM, MD MOO479 22 Name and Address of Facility 21. Signature of Moneral Service Licensee RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in list and overts. Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use or the build to completely filled in by the funeral director, page 2 should be detached for use or the build to completely filled in by the funeral director. that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 menths? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No o 9 Unknown 9 Unknown م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 XNo of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title 142529 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print) 120700LOLANE CIR WALOORF NO 20602 XI MEINDERS SMITH MO 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Reina Natasha Lynch

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2005 38323

	Registrar	Certificate of Death Reg. No.									
Physician/ ledical Examiner	Decedent's Name (First, Middl REINA	N LYNCH				2. Date of D Month NovemI				ar of Death	3 Time of Death 0750 hrs
	4a. Facility Name (if not institutio 11900 Trolley Lane	, ,						Beltsville			
Funeral Director	5. Social Security Number 103-72-2164	6. Sex 7. Age (In 1 M 2 X F 26	n yrs. last birthda	· -	If Under 1 Year Months Day		Min.	8. Date of Birth	(MY/BBYYYY RY 12	9. Birth Foreigr Cou	place (State or ntryGUYANA
d how any	Usual Residence of Decedent 10a. State 10b. County MD PRINC	E GEROGE'S	c. City, Town or L		WIE						10d Inside City Limits 1 X Yes 2 No
n the Maryland 3a or 28a-f show otified at once.	10e. Street and Number	DOAD		1	10f. Zip Code				g Citizen of WI		ry?
death with the r items 23a o nust be notifi uneral Di	16211 ECKHART 11. Marital Status	12. Was Decedent Eve	er in U.S. 13		207 Decedent of Hi , specify Cuba	spanic Orig		ofy Yes or No-	14. Race		an Indian, Black,
s after death ral", or iten niner must by Funo		arried Armed Forces? 1 Yes 2 orced If Yes, Give Year or Dates:		1 🗌 Y	es 2 🔀 No	specify:			Specify:		BLACK
36 in 72 hour han "natu lical Exan pleted	15. Decedent's Education (Spe Elementary/Secondary (0-12)		duri	ng mos	Usual Occupa t of working life CY ASSI	e. DO NOT			16b. Kind of Bu		dustry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica To Be Comple	The Father S Hame (Files, Middle						MAR	ILYN O	aiden Surname	NG	
MD 21 ad 2 should alth and Me an 27 is ma aumatic ev	19a Informant's Name/Relations COLIN LYNCH JR		· ·		\ -			ral Route Num TE,MAI	ber, City or Tow RYLAND	n, State, 207	
- D - E - E	20a Method of Disposition 1 [X] Burial 2 Cremation	n 3 Removal from State	20b. Place of D crematory					Date	20c. Location		
Baltimore, permit. Pages I an Department of Hea Important: If iten injury or other tr	4 Donation 5 Other S 21. Signature of Funeral Solvice		GATE C		EAVEN me and Addres				SILVE KINS F		
	23a. Part I. Enter the disease, or	r complications that caused the	e death. Do not e						VER, MAR		20785 Approximate Interval
Physician /Medical 5xaminer	failure. List only one cause Immediate Cause (Final disease	on each line.									Between Onset and Death
, and the same of	or condition resulting in death) Sequentially list conditions,	Due to (or as a conseque).	ence of):								
ted Insit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	С,									
cuted nd transit		Due to (or as a consequent	ience of):								
38760, rtificate be executed ling physician and eas the burial - transi	UNPENDED IF FEMALE:	AMENDED 23c. If yes, outcome	of pregnancy						23d Date o	f delivery	
∞ ≒ ⊚ ≤ ⊆		the 1 Live birth 4 Pregnant at tin	2	=	Il death 3 er (Specify)	Ectopio	c pregnan	су	Month	,	ay Year
P.O. Box 6: es that the death cert gened by the attending be detached for use at the properties.			ut not resulting in	the un	derlying cause	given in Pa	art I.		F (b)	-	he cause of death?
cords, Paw requires that be consigned by a should be consigned by the constant of the constant								24a. Was a	an 24b.	Were au	copsy findings available ompletion of cause of
Records, I The law requires ficate has been sig page 2 should be	<u> </u>			-				perfor	med?	death?	
Vital Recysician: The system: The director, page		Lloopitel.			_	Ce of Death					
f Vit	1 Yes 2 No	28a Date of Injury	28h Tin			Other ₄ jury at Work			Residence 6		: Scene
Division of Vital Records, spital or Attending Physician: The law require neral Director: After this certificate has been sifilled in by the funeral director, page 2 should be certification: To Re Completed	1 Natural 5 Per 2 Accident Investigation	restigation FOUND: FOUND: Nov 11, 2006	FOUN 0650 h	D: nrs	1 🗸	Yes 2	No S	Subject sho		- a - a - D	ral Route Number, City
Divis pital or A ours after eral Dire filled in b	3 Suicide 6 Cou	28e. Place of Injure ermined (Specify) Work		n, street	, тастогу, опісе	bullaing, et		or Town, S			an Route Number, Oity
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		Physician: To the best of my kaminer: On the basis of examinand manner stated.	nowledge, death	occurre estigatio	ed at the time, on, in my opinio	date and place on, death oc	ace, and o courred at	due to the caus	e(s) and manne and place, and	er as start due to th	ed. e cause(s)
	29b Signature and title of certif	Geef R	D		- 1	nse number C.M.E.			Novembe	•	
CABI	30. Name and address of person Tasha Greenberg MI			111 F	Penn Street	t, Baltimo	ore, MD	21201			
Stat Registra			Signature	シ				·			
DHMH 17 Rev 1/200		- June A	ORIO	SINAL	_						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Nov.15,2006 Year **Physician** Robert H. Link 11:25 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner National Lutheran Home Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2□ F 89 357-14-5020 Dec. 14, 1916 Illinois Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show other traumatic event, the Medical Examinar must be notified at Md. Rockville Montgomery 1X Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 9701- Veirs Drive 20850 IISA 238 Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes X ☐ No Specify: Specify: White ₩Vidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lile. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Art Educator Education 5+ permit. Pages 1 and 2 should be file Department of Health and Mental Hy; Important: If tem 27 1s marked other any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Louis L. Link Anna Naq1 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 33-Hilderwood Dr., Murray, Ky. 42071 Harriet Chambers-Daughter Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Metroportican Crematory-11/17-Alexandria, Va. 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hysong Co., Inc. 2222-Wisconsin Ave., NW, Wash,, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final accide week **Physician** AVO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner G Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician ar s the burial-t Box 68760. Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions of ntributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 HNO Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 this 28c. Injury at Work? Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 5 Pending investigation 1 Matural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 To the 29d. Date signed (Month, Day, Year) November 16, 2006 29c. License number 29b. Signature and title of certifier

State

31. Date filed (Month, Day, Year) NOV 2 0 2006

CHARLES

32. Registrar's Signature

KARESI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.

Registrar

9701- VEIRS DR. ROCKVILLE MM

06-08688 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Raul Olan Lopez 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day November 15, 2006 0224 hrs Medical Examiner Raul 01an Lopez 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Salisbury Wicomico Peninsula Regional Medical Center 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director M Sopritre)o None Feb. 27, 1973 1 X M 2 33 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Coahuila 1 X Yes 2 No or 28a-f show Mexico Coahuila Piedras Negras permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho rights or other traumalic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ద C. Simon Galvan 614 Mexico None Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes White 1 X Yes 2 No specify: Mexican Specify: If Yes, Give Year Widowed Divorced ģ Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 General Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elvia Lopez Gonzalez Be Belizario Olan Jimenez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 120 19a. Informant's Name/Relationship (Type, Print) (Father) Simon Galvan 614, Piedras Negras, Coahuila, Belizario Olan Jimenez 20c. Location - City or Town, State Piedras Negras 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Jardin De Los Angeles 11/25/06 Coahuila, Mexico Donation 5 Other Specify. 22. Name and Address of Facility Olinger Mortuar 6614 S. Flores, 21. Signature of Funeral Service Ligensee Mortuary Flores, San Antonio, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical a. Gunshot Wound of Abdomen Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical UNPENDED physician the burial -AMENDED Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Fetal death 2 past 12 months? Pregnant at time of Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o þ ے Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 1 V Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 ✓ Inpatient 2 Other₂ ER/Outpatient 3 Nursing Home 5 Residence 6 Other this 1 Yes No 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Subject shot Nov 14, 2006

Death

Year

No

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

November 15, 2006

or Town, State) Maryland Avenue & Smith Street, Salisbury, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed of Vital Division

After Director:

To the Funeral

Medical

30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. State Registrar

2

Natural

Accident

Suicide

29b. Signature and title of certifie

4 V Homicide

29a. Certifier 1

(Checkonly

Pending

Investigation

Could not be

determined

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signatur

(Specify) Local Street

and manner stated

2126 hrs

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

Yes 2 ✔ No

		1	For State Registrar	(First Middle Last)			Cer	tificat	e of D	eath		2. Date of Dea	leg. No.		3. Time	of Death
	Physicia	an		Mary Joan							1	Month Novembe	Day	, 200	2.	16 Pm
	/Medic Examin		4a. Facility Name (If			i		4b. City,	Town, or L	ocation	of Death		4c. 0	County of De	ath	-
,				ry's Hosp		(1 1		Leo If Under	nardt	own If Under	24 Hrs	8. Date of Birti		St. Ma		
	Funeral Director		5. Social Security Nu 577-44-23		M 2∭ F	75	ast birthday) Yrs.	Months	Days	Hours	Min.	(Month, Day	, Year)		irthplace (State Country) aryland	
7	W	-	Usual Residence of I	Decedent 10b. County		10c. City	, Town or Lo	cation			<u>-</u>				10d. Inside	City Limits
	f sho	ō	Maryland	St. Mar	y¹s	Me	chanic	svil	le						1 □ Ye	s 2⊠No
-	r 28a	Directo	10e. Street and Num	ber	<u></u>			10f. Zip	Code				10g. Citiz	en of What	Country?	
	238 o	aiD	25826 S	outh Sand	gates Roa	ad			20659					JSA		
	tems	Funeral	11. Marital Status		12. Was Decedent Armed Forces	?	S. 13. V	Vas Deced f Yes, spec	lent of His ofy Cuban	panic Or Mexical	igin? (Spe n, Puerto f	cify Yes or No- Rican, etc.)	. 1	 Race - Ar Black, Wi 	nerican Indian, nite, etc.	
5	s 1 and 2 should be filed within 72 hours affer death with the maryland. Theath and Mental Hygiene. It heath and Mental Hygiene. It heath and Mental Hygiene at 1 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be recitied at	by F	1 ☐ Never Marrie		1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:			I □ Yes	2 ⊠ No	Specify:	:			Specify:	White	
5	atura ical E		(Specie	15. Decedent's Edu fy only highest grad	cation	- Company of the Comp	16a. Deced	lent's Usua	al Occupat	ion	st of workir	10	16b. Kin	d of Busines	s/industry	
7	Me.	Completed	Elementary/Secon		College (1-4or	5+)	life. L	DO NOT u	se retired)				ъ.	1	055:	
7	led w lygier her th	Co	12 17. Father's Name (i	First Middle Last)			N	urse		18. Moth	er's Name	(First, Middle,			Office	
yland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Ms) Be		McQuilan	Alvey							Ellen 3				
֝֟֟֝֟֝֟֝֟֝ <u>֟</u>	Should nd Me mark	ပို		me/Relationship (T)			19b. Mailin	g Address	(Street ar	nd Numb	er or Rura	i Route Numbe	r, City or	Town, State	, Zip Code)	
Mai	and 2 alth a 27 is		Sandra A.	Eversber	g Daugl				-	od R		Ho11ywo			0636	
ore or	of He of He of of He of oth		20a. Method of Disp	osition Cremation 3 🗆 F	Removal from State	1 .	lace of Dispo emetery, cren	sition (Nai natory or c	ne of ther place,)	D	ate	20c. Loc	ation - City	or Town, State	
Saltimor	Pag tment tant: tant:		4 Donation	5 Other (Specify)			ropolita					200,200 er				ia
מ	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai once.		March	neral Service Licens	Hara	(ener)	>50	P.O.	Box 7	270.	Leona	r Funer	, MD	lome, 20650	P.A.	
S.			Immediate Cause (ne disease, or comp rt failure. List only o Final	lications that cause ne cause on each	ed the feath	Do not ent	er the mod	le of dying	such as ا مست	s cardiac o	r respiratory ar	rest,		Approxim Interval E Onset an	d Death
	Physician /Medical Examiner		disease or condition resulting in death)		a	s a consequ	uence of):		م ه له		·				0<>	
製	20,	er	Sequentially list con if any, leading to im	nditions, mediate	b. Due to (or as			τ	<u> </u>		*					
	cuted Id ransit	Examin	Cause (Disease or i that initiated events	rlying injury	C											
Ď,	cate be executed physicien and the burial-transit	I Ex	resulting in death) L	ast	Due to (or a	s a consequ	uence of):									
8/60,	cate b physic the b	dical		•	d										:	
			IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcom								2	3d. Date of	delivery	
	0 00 0	Physician/M	in the past 12 1 Yes 2 Dunknown	months?	1 □Live birth 4□ Pregnant a 9□ Unknown			Ectopic p Other (s						Month	Day	Year
л О	res that the de igned by the a be detached f	, Ph		icant conditions co	ntnbuting to death	but not res	ulting in the u	nderlying	ause givei	n in Part	ŧ.	23e. Did t	obacco u	se contribute	to the cause	of death?
GS,	quires n sign	d by										1 🗆 `	res 2]No 3□	Probably 4	Onknown
Hecords,	law requires that the as been signed by th .2 should be detache	Completed										24a. Was		24b. Were	autopsy findin- o completion o	gs available f cause of
I	The ate h page	Com										perfo	rmed? 2 No	death 1 🗆 Y	? es 2□ No	
Vital	sicien: Th certificate rector. pag	Be	25. Was case reference examiner?		Hospital:				Othe	P1		(Check only o				
0	Phys r this ral dir	To	1 Yes 2 X	140	28a. Date of In	jury	ER/Outpatier 28b. Time o		28c. Injury Work	4 14		me 5 Residence R			pecify)	
on	nding Ph ath. r: After th e funeral	atior	1 Natural 2 Accident	5 Pending investigation	(Month, D	ay Year)	Injury	м		es 2]No					
Division of	or Attended liter ded Director in by th	Certification:	3 Suicide 4 Homicide	6 Could not be determined	289. Place 01 II	njury - At ho	ome, farm, str y)	reet, factor	y, office			28f. Location (City or To			Rural Route N	umber,
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certification will be supported in by the funeral director.	edical Ce	29a. Certifier (Check only	1 Certifying Phy 2 Medical Exam	/sician: To the bes											e(s)
	thin 24 the F the F mplete	Medi	one) 29b. Signature and		and manner s				c. License						onth, Day, Year	
	7.₹ 5 <u>9</u>		250. Giginature and	(N)					> 61		3			17.		
- 1	N. C. C. C. C. C. C. C. C. C. C. C. C. C.		30. Name and addr	ress of person who o	completed cause of	death (Iten	n 23a) (Type,		'							
	5		D hananjay	Bhavsar, M.			Notch R		ollywo	od, N	MD 20	636				
	Sta Regist	ate	31. Date fited (Mon	NOV2 0	2000 32. Regis	strar's Signa	ature	book								

		4	For Amend #1 per	State of Maryland	2000artmm Certificat	nt of Health and I te of Death	Mental Hyg	iene2 () () 6 eg. No.	38321
	Physicia	ın	1. Decedent's Name (First, Middle, Last)	Thelma Marie	Lowery)	2. Date of Deat Month	th Day Year 17 06	3. Time of Death
,	/Medic Examin		4e. Facility Name (If not institution, give st	reet and number)		Town, or Location of Death	k	4c. County of Deal	th , ,
	Funeral Director		5. Social Security Number 6. Sex 10	7. Age (In yrs. las		r 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day)	Year) 9. Bir	hplace (State or Foreign ountry)
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
;	the Mar 28a-f sh	Director	Many land Frederice 10e. Street and Number	k Pain	t of Roel	(S p Code	1	l0g. Citizen of What Co	1 ☐ Yes 2 ☑ No ountry?
	th with	a D	1596 Bowis Driv	18		1777		U.S. of A	,
320	irs after dea ii', or itema zaminer m	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: 	13. Was Dece If Yes, spe	edent of Hispanic Origin? (Secify Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
9500-CLZ1	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. A dother then "natural", or itema 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		life. DO NOT	ork done during most of wor		16b. Kind of Business Retail	/Industry
Maryland 2		To Be Co	17. Father's Name (First, Middle, Last) Oliver Frankl	in Hanvey	00,16.5		ne (First, Middle,	Maiden Sumame)	
	od 2 Ithau 27 io		19a. Informant's Name/Relationship (Type		100/1 0	S (Street and Number or Ru	Peint of	r, City or Town, State, Rocks	Zip Code) MD 21777
altimore,	0 O - L		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	20b. Pla	netery, crematory or	other place)	Date 0/06	Love 1+5	Town, State
Balti	permit. Page Department of important: if eny injury or			mong h &	22. Name :	and Address of Facility n. Functal Char	pel SE, Les	esburg V	120175
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	cations that caused the death.	Do not enter the mo	de of dying, such as cardia	c or respiratory an	rest,	Approximate Interval Between Onset and Death
-	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseque		aft fouly	re		I WPP/s
8760,		al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque					
P.O. Box 687	The law requires that the death certificate be executed tae has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal (4 ☐ Pregnant at time of dea	death 3 Ectopic			23d. Date of de Month	olivery Day Year
	uires that signed b Id be deta	d by Pt	Part II. Other significant conditions con	tributing to death but not resul	lting in the underlying	cause given in Part I.		obacco use contribute f res 2□No 3□F	o the cause of death?
Division of Vital Records,	The law require te has been siyage 2 should t	Completed	Usiabeles n	rely'tus.				sy prior to rmed? death?	utopsy findings available completion of cause of
/ita	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	ospital:		000	eath (Check only o		
on of \	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 E	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No		dence 6 Other (Spanow injury occurred	ecify)
Divisi	at or Attending s after death. I Director: After id in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, facto	ory, office	28f. Location (S City or Ton	Street and Number or F vn, State)	Rural Route Number,
	Hospitat 24 hours a Funeral E	edical (29a. Certifier 1 Certifying Physics (Check only one)	sician: To the best of my knowner: On the basis of examinati and manner stated.	viedge, death occurre ion and/or investigati	d at the time, date and plac on, in my opinion, death occ	e, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the To the Complet	Me	29b. Signature and tife of certifier		2	9c. License number		29d. Date signed (Mor	nth, Day, Year)
•	Q		30. Name and address of person who co	Hiron A	Shah 23a) (Type, Print)	D 57643 V Fre don't		11-17-06	
	3		65.CT6	112	nson D	v Fredon	of mg	24702	
ø	St Regist	ate rar	31. Date filed (Month Day Y2) 0 2	JUb 32. Signat	to Append				

Physician /Medical Examiner **Funeral** Director 10a. State Director

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Completed

23a or 28a-f show 5 Maryland 21215-0036 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked oth eny lighty or other traumatic event 2008. Baltimore,

Malat

Physician /Medical

Physician/Medical þ Completed Be 2 After this Certification: death.

IF FFMALE

Examiner or Attending Physicien: The law requires that the death certificate be executed Ö Records, Division of Vital I Director: A filled in by within 24 hours a To the Funeral C completely filled 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month EILEEN ISACKSON MALATESTA 06 NOU, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Plat Civista Medical enter harles Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1 □ M 2 🛛 F Hours 474-16-0122 APR. 3,1922 MINNESOTA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8405 PERRY PLACE 20646 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2/CM\o If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. GOVERNMENT Elementary/Secondary (0-12) College (1-4or 5+) 12 CHEIF OF SUPPLIES & ACCTS. U.S. DEPT. OF NAVY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) AUGUST ISACKSON JOHANA PETERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTHONY MALATESTA-SPOUSE 8405 PERRY PLACE, LA PLATA, MARYLAND 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XDXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEMORIAL GDNS. 11-22-06 WALDORF, MARYLAND 21. Signature of Fuperal Service Licensee MQ0479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of cyling/such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each me. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last therosclerote Cardio vascular Desecne 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Lymphocytic Leuhemia 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗍 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) individual manner stated. 29b. Signature, 29c. License number 29d. Date signed (Month, Day, Year) D-46419 eted cause of death (Item 23a) (Type, Print) 404 E. Charles St. La Plata 14. Letch GBRd M. M.D. Charlene

Medical

State Registrar 29a. Certifier

31. Date filed (Month Pa) (

		For State Registrar			partment of He ertificate of De		R	eg. No.	006	38329
Physici	an	Decedent's Name (First, Middle, La.					2. Date of Dea Month	Day	Year	3. Time of Death
/Medic		ROBERT W		TH			November	17,	2006	5:15 A M
Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or Lo			4c. C	County of Death	
		25670 Frenchtown 5. Social Security Number 6. S		(In yrs. last birthd	Westor		8. Date of Birth		Somerse	
Funeral Director		220-32-1244	⊠M 2□F	72 Yrs	Months Days	Hours Min.	April 16,	1934	l Mar	place (State or Foreign ntry) Tyland
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
f sho	5	Maryland Somers	et	West	cover					1 ☐ Yes 2 🛣 No
28a	rect	10e. Street and Number			10f. Zip Code		1	I0g. Citize	en of What Cou	ntry?
3e or	Funeral Director	25670 Frenchtown	Road		21	871			11.9	5.A.
ms 2	era	11. Marital Status	12. Was Decedent Ev	rer in U.S. 1	Was Decedent of Hisp If Yes, specify Cuban,		ecify Yes or No-	14	4. Race - Ameri	can Indian,
be filed within 72 hours after deeth with the Maryland tal Hygiene. Id other than "natural", or Items 23e or 28e-f show event, the Medical Examera.	by Fur	1 ☐ Never Married 2 📆 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			Mexican, Puerto Specify:	Rican, etc.)		Black, White, Specify: Whi	
2 hot		15. Decedent's E	ducation	16a. De	cedent's Usual Occupation	on		16b. Kind	d of Business/In	idustry
nin 7. nin in Medi	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ude completed) College (1-4or 5+	(G life	ive kind of work done dur a. DO NOT use retired)	ring most of work	ing			
d with	E O	7	0011090 (1 401 01	Wat	cerman			Sea	afood	
2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Me	BeC	17. Father's Name (First, Middle, Last,			11		e (First, Middle,	Maiden S	Sumame)	
should b nd Ment marked umatic e	10	Dulaney Meredith				Lena F	rench			
2 sho and l is mu		19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Street and	d Number or Rur	al Route Number	r, City or	Town, State, Zip	Code)
and salth n 27		Lorraine Meredit	h (Wife)		570 Frenchto					.871
ges 1 and 2 should t of Health and Men if item 27 is marke or other treumatic		20a. Method of Disposition 1 Surial 2 Cremation 3	Removal from State	20b. Place of Di cemetery, of	sposition (Name of crematory or other place)		Date	20c. Loc	ation - City or To	own, State
Pages ment of ent: If it ury or o		`4 □Donation 5 □ Other (Specif		Fairmour	nt Cemetery	11/2	0/06	Fair	mount,	MD
permit. Pages Department of I Importent: If its any injury or o		21. Signature Tuneral Service Licer	Sul f	<	22. Name and Address Bradshaw & 306 W. Main	Sons Fu	neral Ho	me	11017	
ja-		23a. Part1. Enter the disease, or com shock, or heart lailure. List only	plications that caused the	he death. Do not	enter the mode of dying,	such as cardiac	or respiratory arr	est,	21817	Approximate
		Immediate Cause (Final	one cause on each line	a. 11 0 m	lada maa 20	H. Lu	- el.	a edici.	a luca	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Dua to (or as a	consequence of):	nemome of i	ne sun	J. CXREC	ce/me,	xinge	14
Examiner			D00 t0 (01 as a	consequence or).						
×	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	consequence of).						
uted	Examiner	Cause (Disease or injury	_							
exec in an	Еха	resulting in death) Last	Due to (or as a	consequence of);						
ificate be executed g physician and as the burial-transit	edicai		d							
= 0 e	led									
eath certi attending I for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. Il yes, outcome of 1 Live birth 2		3 DEctopic pregnancy			23	3d. Date of deliv	•
deat	sicie	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at ti		5 Other (specify)				Month	Day Year
at the by th	hys	9 Unknown								
The law requires that the death cert te has been signed by the attendingage 2 should be detached for use	by	Part II. Other significant conditions of	contributing to death but	not resulting in th	e underlying cause given	in Part I.	1 1 1 1 1			he cause of death?
w requires t been signe should be	leted						24a. Was a	ın	24b. Were auto	ppsy findings available
The larate has	Comple						autops	sy med?	prior to co death?	impletion of cause of
	C	25. Was case referred to medical				IC Diago of Dogs	1 Yes	_	1 🗌 Yes	2 L No
ysiclen: is certific director,	O B	examiner? 1 Yes 2 No	Hospital:	2 □ EB/Outpa	Othor		h <i>(Check only or</i> ome 5 ☐ Reside		Other (Special	6.1
Phys er this eral di	I	27. Manner of Death	28a. Date of Injury	28b. Tim	e of 28c. Injury a	4 Nursing Fig	28d. Describe h			(y)
th. Afte	tlor	1 Natural 5 Pending 2 Accident investigatio	(Month, Day n	Year) Injui	y Work?	s 2 No				
r Attending Physiclen: er death. rector: After this certific by the funeral director,	fica	3 Suicide 6 Could not b	e 28e. Place of Injur	y - At home, larm,	street, lactory, office		28f. Location (S	treet and	Number or Run	al Route Number,
after Dire	Certification:	4 Homicide	building, etc.	(Specify)			City or Town	n, State)		
To the Hospital or Attandin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	Medical C	29a. Certifier 1 Certifying Pt (Check only one)	nysicien: To the best of miner: On the basis of e and manner state	examination and/o	eath occurred at the time, r investigation, in my opin	date and place, ion, death occur	and due to the cred at the time, d	ause(s) a late and p	and manner as s place, and due to	stated. o the cause(s)
o the ithin o the omple	Me	29b. Signature and title of certifier	and maillet statt		29c. License n	number	2	9d. Date	signed (Month,	Day, Year)
F 3 F 8	4	1 tour is	Vals 1	WO.	20014				20,20	
		no News and address all assess who		ab (las a 02s) (To	D-:-N					
		PANPIT P. KLI	14. 145 E	- Courl	18 met, de	distruct	7. mo	2/8	804	
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar		South .					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Miller /Medical November 14 2006 11:40PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Wicomico Nursing Home
5. Social Security Number Salisbury
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Wicomico 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Funeral 1**X** M 2□ F Months Yrs. 193-09-5153 Director 97 4/28/1909 Pennsylvania Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location ir then "natural", or Items 23a or 28a-f show The Medical Examiner must be netitied at 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Wicomico Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4997 Ladys Court 21822 USA 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ white 3 Midowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 Inent of Health and Mental Hygiene.
snt: If item 27 Is marked other then "nat ury or other treumatic event, I'm Mudical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Bkwy. Pressed Metals 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel Miller Emma Craft 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4997 Ladys Court, Eden, MD 21822 Larry Miller /son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Mountain Cemetery 11/18/06 Brockport, PA Signature of Funeral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CFSP Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certiticate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical as the esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Month Day 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ should be ZHEIMERS MENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 has No No 1□ Yes 2□ No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 10 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pendina death. investigation 2 Accident 1 Tes 2 🗌 No within 24 hours atter death To the Funerel Director: , completely filled in by the t 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) determined 4 Homicide Hospitel 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

32. Registrar's Signature NOV 1 6 2006

MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

M.THIMMANAYAP

MD

614

29c. License number

D-0060515

29d. Date signed (Month, Day, Year)

SHORE DR SAUSBULY MD 21804

Martin

98

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death Month 25 November 2006 1:15 P. 4c. County of Death 4b. City, Town, or Location of Death Washington Hagerstown 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, August 6 7. Age (In yrs. last birthday) Min Mary land Months Days Hours Yrs. 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No Hagerstown 10g. Citizen of What Country? 10f. Zip Code 21740 U.S.A. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 💆 No Specify: White Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) Anna Baer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18006 Horst Lane Hagerstown, Md. 21740 20b. Place of Disposition (Name of 20c. Location - City or Town, State Reiff Mernion Le Church Cemetery 11/30/06 Cearfoss, Md. 22. Name and Address of Facility
Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. Approximate Interval Between Onset and Death

1. Decedent's Name (First, Middle, Last) **Physician** Fannie /Medical 4a. Facility Name (If not institution, give street and number) Examiner 18006 Horst Lane 5. Social Security Number **Funeral** 1 □ M 2 X F 215-64-034 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County in than "natural", or Items 23a or 28a-f show the Medical Examiner rust be notified at MD. Washington Director 10e. Street and Number 18006 Horst Lane death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other fraumatic event, the Medical Examinat OREs. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) S. Lesher Horst 19a. Informant's Name/Relationship (Type, Print) Ruth Martin/Daughter 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is its lead on the cause). sician and burial-transit or Attending Physicien: The law requires that the death certificate be executed Exami resulting in death) Last Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? signed by the a Id be detached fo 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions þ

plications that caused the death. Do not enter the mode of dying, such as care one cause on each line.	
a. Due to (or as a consequence of):	io vascular dises
b. Due to (or as a consequence of):	
CDue to (or as a consequence of):	
d,	
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of deliver Month
contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the

cause of death? ably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

autopsy 1 Yes

1 Tes 2 No

Year

			2	Place of Death	(Che	eck only one)	
al: 1 □ Inpatient	2 ER/Outpatient	3□ DOA	Other:	4 Nursing Hom	ne	5 X Residence	6 □Other (Specify)
a. Date of Injury	28b. Time of	28c.	Injury at	2	8d. [Describe how inju	ury occurred

rred 28 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier	1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check only	2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s)
one)	and manner stated.

29b. Signature and ti

on who dompleted cause of death

State Registrar

DHMH 17 Rev 1/2001

been si should

s certificate has the

this After thi

Director:

within 24 hours after To the Funerel Dire

Completed

Be

2

Certification:

Medical

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

Hospit

2006

Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month 2:11 A M **Physician** ROBERT B. MILLER 24, 2006 Nov. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 1/20/1949 5. Socia**5 A**curity Number 217–75–7501 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1₩ 2□ F Maryland 57 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Show 27 is marked other than "naturel", or items 23a or 28a-f shov treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 → No PA York Delta Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6851 Woodbine Road 17314 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 34 0 021 0 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: spec white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry id Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) Construction electrician 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fit and Mental H Be Eugene S. Miller Florence E. Rader 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 sh Department of Health and Important: if item 27 ie m any injury or other treum once. Tacqueline Kay Miller- wife 6851 Woodbine Rd., Delta, PA 17314 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Evans Eagle Crematory 11/26/06 Leola, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa of Funeral Sepripe Licenses 22. Name and Address of Facility Harkins F.H.Inc.600 Main St., Delta, PA 17314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Peritonitis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner schemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ol): Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Miller Robert M800439749 Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by certificate has been sign rector, page 2 should be Encephalopathy 1 Yes 2 No 3 Probably 4 Unknown Cardio Pulmonary 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To the musping after death.
within 24 hours after death.
To the Funeral Director: After this of Medical Certification: To 27. M nner of Death 28a. Date of Injury (Month, Day Year) 28b. Time ol Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40819 November 24, 2006 30. Name and address of person, completed cause of death (Item 23a) (Type, Print) 500 Upper Chesa peake Drive, Bel Air, MD 21014 Zamora MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

DEC 0

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

			State Registrar			Certific	ate of l	Death		F	Reg. No.			
			1. Decedent's Name (First, Middle, La	st)					2	2. Date of Dea Month	ath Day	Year	3. Time of Deat	h
	Physicia /Medic		Pauline	C. Nort	ris						er 17,		4:45A	М
-	Examin		4a. Facility Name (If not institution, giv			4b. (City, Town, or	r Location			4c. County			
			Glade Valley Nurs	sing Center	r	W	alkers	ville	!		Fred	leric	s.	
	Funeral		Social Security Number 6. S		e (In yrs. last birt	hday) If U	nder 1 Year ths Days	If Under Hours	24 Hrs. 8	Date of Birt	1916	9. Birthp	place (State or Fore	aign
	Director		217-80-0657	□ M 2 Ϊ XF	90	Yrs.	uis Days	110013	M	arch 2	4, 1916	Mai	ryland	
	p ,	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n and anation							Od. Inside City Lim	nito
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	ith th	5	10e. Street and Number	d Foot		101	. Zip Code	1044			10g. Citizen of		ntry?	
	eth v	Funeral Director	5125 Durham Roa		- : !! 0	T			0.40			U.S.A. 4. Race - American Indian,		
	er de	nue	11. Marital Status	12, Was Decedent		If Yes,	specify Cuba	an, Mexicar	n, Puerto Ri	fy Yes or No- can, etc.)		ck, White,		
36	within 72 hours after deeth with the Maryland ene. then "naturel", or iteme 23a or 28a-f ehow ite Madical Exempler must be matified at	byF	1 ☐ Never Married 2 ☐ Married 3 ② Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ H If Yes, Give Year or Dates:	40	1 □ Y	s 2 No	Specify:			Specil	y: Wh:	ite	
21215-0036	ture sture	ed	15. Decedent's E		16a.		Usual Occup				16b. Kind of B	usiness/ln	dustry	
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	e filec I Hyg othe	Bec	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name (First, Middle,	Maiden Sumar	name)		
ā	Ald be fenta rked ric ev	To B	Forest Mi	Lton Dixo	n			Els	ie H	all				
Maryland	should have		19a. Informant's Name/Relationship (Type, Print)	rint) 19b. Mailing Address (Street and Number or Run						er, City or Town	, State, Zip	Code)	
	elth a		Betty N. Thomas -	- Daughter	5	125 D	urham	Road	East,	Colum	ibia, Ma	rylar	nd 21044	
ore,	of He item		20a. Method of Disposition	78	20b. Place of cemeter	y, crematory	or other place	ce)	Da		20c. Location	- City or To	own, State	
Ë	Page nent on int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia		Montg	omery	Metho	dist	11/2	1/06	Damascu	s, Ma	aryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelih and Mental Hygiene. Important: If item 27 is marked othar than "natural; or iteme 23a or 28a-1 show any fujury or other treumatic event, the Madical Examination and be collised at ODGs.		21. Signature of Fur eral Service Lice	nsēē () · · ·)	MO 1 A	e and Addre	ss of Facili	ty i ame	РΔ	Funera1	Ноте	3	
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68760,	eath certificate be executed attending physicien and for use as the burial-transit	/Medical		d										
×	ding page as	Me	IF FEMALE:	23c. If yes, outcome	of programmy									
Bo	death c	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death		oic pregnancy	1				ate of delive onth	ery Day Year	
o.	D 0 D	Completed by Physician	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	3 🗆 Otne	r (specify)							
۵.	requires that the leen signed by th hould be detache	된	Pag-IL Other significant conditions	contributing to death b	ut not resulting in	the underly	ing cause giv	ren in Part I	l.	23e. Did to	obacco use con	tribute to t	he cause of death?	?
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Division of Vital Records,	ding Phy h. After this funeral c		27. Manner of Death	28a. Date of Inju	ry 28b. T	lime of	28c. Injur Wor				now injury occur		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and p								cause(s) and m	anner as s	tated.	
	the h	one) and manner stated. 29b. Signature and title of centier 29c. License nun												
	viit To con								-	1.	29d. Date signe	Month,	7	1
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	\		30 Name and address of person who	(Type, Print)	A	ik	FOE	0 1	10 -	217	07			
			31. Date filed (Month, Day, Year)			1	V-	1		2				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Veer **Physician** 5:25A M Hurley Francis Offenbacher November 12 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Clavert Memorial Hospital Prince Frederick Calvert Hrs. 8. Date of Birth
MiMarch 18,1925
WashingtonDC 7. Age (In yrs. last birthday) 81 Yrs. 6. Sex }☐ M 2☐ F **Funeral** Days Months Hours Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel; or Items 23a or 28e-f ehow enty injury or other treumatic event, the Medical Examinating in notified at once. 17 Yes 2 □ No MD Calvert Solomons Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13488 Stowaway Court 20688 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hurley Franklin Offenbacher Mary Agnes Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Offenbacher/Wife 13488 Stowaway Ct. Solomons, MD 20688 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place)
4 Donation 5 Other (Specify)

Brinsfield-Echols 11/14/06 Charlotte Hall MD 21. Signature of Funeral Service Licensee M00945 22 Name and Address of Facility AREHART - ECHOLS FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20646 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STROKE Physician /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner FAILURE physicien and the burial-transit RENAL Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, BACTEREHIA Physician/Medical IF FEMALE: MALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes No No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification: To Impatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number HD/ D0060638 N. Hendono 11/13/06 HOSPITAL ROAD 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20678. **MENDON CA** PRINCE NAYANTORA FREDERIUL

State

Registrar

31. Date filed (Month, Day, Year)

NOV 16

2006

32. Figistrar's Signature

State Amend #2	State of Ma per Phys/F	TH 11-20	Centific	cale of E	eaith and i Death		3. No.	00	38336
1. Decedent's Name (First, Middle, L.	ist)		W 5			November		1001	3. Time of Death
	utman					November		2006	3:00 P M
ta. Facility Name (If not institution, gi Vindobona Nurs			4b. 0	-	Location of Deat		4c. County	of Death Frede	riok
		e (In yrs. last birt	thday) If U	Inder 1 Year	If Under 24 Hrs			9. Birthol	ace (State or Foreig
	1□M 2√F		Yrs. Mon	nths Days	Hours Min.	March 14	, 1916	Count	yland
10a. State 10b. County		10c. City, Town			_			10	Od. Inside City Limits
Maryland Frede	rick			rederi	ck	10	g. Citizen of V	Mhat Caus	
10e. Street and Number 5101 A. Jeffers	on Pike		101	f. Zip Code 217(13		nited		,
11. Maritat Status	12. Was Decedent B	Ever in U.S.	13. Was D			1 -		e - America	
1 ☐ Never Married 2 Married	Armed Forces?					specify Yes or No- to Rican, etc.)		ck, White, e	etc.
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Y€	es X□ No	Specity:		Specify	y: W	Mite
15. Decedent's E (Specify only highest gi			(Give kind o	Usual Occupa of work done di OT use retired)	uring most of wo	rking	5b. Kind of Bu	usiness/Ind	lustry
9			Opera					phone	2
17. Father's Name (First, Middle, Las Arthur W. Mathew						_{ne (First, Middle, M.} .cie Magah		ne)	
19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Add	dress (Street a	nd Number or Ru	ural Route Number,	City or Town,	State, Zip	Code)
Hueston Putman /	Husband	510			D 11	The of conf	ck MD	2170	3
THE PERSON NAMED IN	Habbana				son Pike				
20a. Method of Disposition		20b. Place of cemeter	Disposition y, crematory	(Name of or other place	•)	Date 2	Oc. Location -	City or Tov	wn, State
20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 4 ☐ Dopation 5 ☐ Other (Spec	□Removal from State	20b. Place of cemeter	Disposition y, crematory ikes Co	(Name of or other place emetery	y 11/1	Date 20 6/2006 F	oc. Location - eagavi	City or Tov	wn, State Maryland
20a. Method of Disposition 1 🖔 Burial 2 ☐ Cremation 3	□Removal from State	20b. Place of cemeter	Disposition y, crematory 1kes Co 22. Nam	(Name of or other place emetery ne and Address	y 11/1 s of Facility	Date 20 6/2006 F Stauffer	oc. Location - eagavi Funera	City or Tov 11e, 1 Hom	wn, State Maryland ne
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Physici /Media Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.

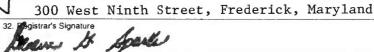
Priysician /Medical Examiner

Baltimore, Maryland 21215-0036

State Registrar

Robert L. Kaufmann 31. Date filed (Month, Day, Year)

30. Name and address of person who comp



use of death (Item 23a) (Type, Print)

NOV 2 0 2006

21701

DHMH 17 Rev 1/2001

PLYLER

EDWARD PERRY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	orato or mary		rtificate of l		Reg.	2000	38338
	Physici	an	1. Decedent's Name (First, Middle, La	st)				Date of Death Month	Day Year	3. Time of Death
	/Medic	cal		nry Puli	tz	I		November	16, 2006	1:32 p.m.
	Examir	ier	4a. Facility Name (If not institution, giv	,		-	Location of Death		4c. County of Death	
	Funeral		16747 Three Noto 5. Social Security Number 6. S	Sex 7. Age (In)	yrs. last birthday)	If Under 1 Year	dge If Under 24 Hrs.	8. Date of Birth	St. Ma	place (State or Foreign
	Director		512-28-0328	X M 2 □ F 7.	5Yrs.	Months Days	Hours Min.	(Month, Day, Ye 12–22–30	ar) Cou	ntry) Souri
	and w t		Usual Residence of Decedent 10a. State 10b. County	10c.	. City, Town or Lo	ocation				10d. Inside City Limits
	Mary I-f sho	tor	Maryland St. Mary	71e	Ridge					1 □ Yes 2√□ No
	th the	Director	10e. Street and Number	7. 3	Riuge	10f. Zip Code		10g.	Citizen of What Cou	ntry?
	ath wi		16747 Three Notch			2068			United Sta	ates
	items	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever is Armed Forces?	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
93	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	3 Widowed W Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	White
5-0036	72 hou natura dical E	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occupa	ation	16b	. Kind of Business/In	dustry
7	vithin ane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired)	ng		
7	filed within Hygiene. ther than " ent, the Me	ပ္ပိ	12 17. Father's Name (<i>First, Middle, Last</i>))	Unk	nown	18. Mother's Name	(First, Middle, Maid	Communica	tions
land	lid be lental rked o	To Be	Charles Pultz				Unkno		ion ourname)	
Mary	2 should be and Mental is marked craumatic ever		19a. Informant's Name/Relationship (**	19b. Mailir	ng Address (Street &			ty or Town, State, Zip	Code)
e, e	and 2 ealth m 27 i		Christy Pultz/ Da					Illinois	61530	
ב פ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Inemoval nom State		sition (Name of matory or other place			. Location - City or To	
baltimor	artmer artmer ortant Injury	- 8	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer	v) B	rinsfie.	Ld-Echols	Cr. 11-18	3-2006 Ch	arlotte Ha	all, MD
Ď	Dep.		Kyle S. Simon	to un	1206 22	2955 Holls	vwood Roa	nsileid F d. Leonar	uneral Hon	ne, P.A. 20650-0279
	E 8 . S		23a. Part1. Enter the disease, or com shock, or heart failure. List only						,	Approximate Interval Between
	Physician	ĺ	Immediate Cause (Final disease or condition	a. Due to (or as a con-					1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con-	equence of).		0		7	
		er	Sequentially list conditions, if any, leading to immediate	b Due to (or as a cons	sequence of):					
	cuted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•						
Ž,	e exectan ar		resulting in death) Last	Due to (or as a cons	sequence of):					
00/00	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Medical		_d						
X	in Bush		IF FEMALE:	23c. If yes, outcome pf pre	anancv					
ם כ	sician: The law requires that the death ce certificate has been signed by the attendi rector, page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□F 4□Pregnant at time o	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	Day Year
5	at the by the tache	hys	9 □ Unknown	9□Unknown						
ה ה	res tha	þ	Part II. Other significant conditions of	ontributing to death but not	resulting in the ur	nderlying cause give	n in Part I.		o use contribute to the	
ecords,	requi	Completed						1 Yes	2 No 3 Prob	ably 4 Unknown
ב	has t	mple						24a. Was an autopsy performed	prior to cor	psy findings available mpletion of cause of
ומ	in: Th	e Co	25. Was case referred to medical					1 Yes 2		2 No
>	ysicia is cert direct	To B	examiner? 1 No 2 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatien	0.0	26. Place of Death		6 □Other (Specif	
5	ng Ph fter th neral		27. Manner of Death	28a. Date of Injury (Month, Day Year				8d. Describe how in		
2	tendii leath. tor: A the fu	catic	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 □ Y	es 2 □ No			
5	lor At after d Direct in by	Certification:	4 Homicide determined	28e. Place of injury - Albuilding, etc. (Spe	t home, farm, stre ec <i>ify)</i>	eet, factory, office	2	8f. Location (Street City or Town, St	and Number or Rura ate)	I Route Number,
	spital	a C	29a. Certifier CertifyIng Ph	ysician: To the best of my i	knowledge, death	occurred at the tim	e, date and place, a	and due to the cause	e(s) and manner as st	ated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical Exam	niner: On the basis of exam and manner stated.	ination and/or inv	estigation, in my op	inion, death occurre	ed at the time, date	and place, and due to	the cause(s)
	To t	Σ	29b. Signature and title of certifier	b		29c. License	number		Date signed (Month,	Day, Year)
			I WM W	7		D6228		11	1/18/06	
			30. Name and address of person who of	completed cause of death (II	tem 23a) (Type, I	Longer T	Pd he	marden	n, mo 26	21.50
Ę	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	· · · · · · · · · · · · · · · · · · · ·	/ \	UI HI CIOWI	,, see	730

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene (1) (1) (5)

Certificate of Death Reg. No.

			For State Registrar	State of Ivia	ryland /		ficate of		л ментат ту	rgienę∠ (Reg. No.	JUO	30333
Ph	ysicia	an	1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month	eath Day	Year	3. Time of Death
	Medic amin		42 Facility, Name (If not institution, g	· · · · · · · · · · · · · · · · · · ·	h.b	C4- 4	b. City, Town, o	or Location of De	1,701	4c. Cour	nty of Death	3070 M
Fun Dire	eral ctor		215-36-2228	11 3 TM 2□ F	16-0; (In yrs. last) 81		Months Days	If Under 24 Hours M	8. Date of Bi (Month, Di 1/16/1	rth ay, Year)		place (State or Foreign ntry) yland
rland	=	1	Usuat Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loca	tion			-		10d. Inside City Limits
a-f ah	pelli	ctor	Maryland Wicomi	.co	Sal	lisbur	·У					1 K Yes 2 □ No
vith th	De no	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen o		ntry?
eath v	must	erai	105 Times Squar	12. Was Decedent E	ver in II S	13 Wa	218		(Coordy Van or N	USA	lace - Ameri	can Indian
s 1 and 2 should be filed within 72 hours after death with the Maryland I Heelth and Mental Hygiene. Item 27 is marked other then "natural", or Itama 23a or 28a-f ahow	Examinar	þ	1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	Armed Forces?			es, specify Cub		(Specify Yes or No erto Rican, etc.)	Spec	llack, White,	
hin 72 ho s. in "natul	Medical	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5+		a. Deceden (Give kin life. DO	t's Usuaf Occup d of work done NOT use retire	pation during most of t d)	working	16b. Kind of	Business/In	odustry
od with	2	Com	6	_	" I	armer	/Truck	Driver		Agric	ultur	9
should be filed withind Mental Hygiene.	atic avant	To Be (17. Father's Name (First, Middle, Last Marion Lee Puse	У				Addi	lame (First, Middle e Parsons	3		
d 2 should lith and 27 is my	traum		19a. Informant's Name/Relationship Marion M. Pusey		1:				Rural Route Numb			
Heel	other	ł	20a. Method of Disposition	01/5011	20b. Place	of Dispositi	on /Alama of		Date	20c. Location		
Depertment of Important: If it			1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	ify)	Wicc Park	mico Mico	ory or other place Memoria	Î 11	/15/06	Salis	bury,	MD
Deper Impor	any in		21. Signal of Funecal Service Life	ensee		音 50	iToway 1 Snow	ruheral Hill Rd	Home Pro	ofession oury, M	nal As D 2180	ssociation 14
Physic /Med	ical		23a. Fart1. There the disease, or consider, or heart failure. List online mediate Cause (Final disease or condition resulting in death)	mplications that causberry one cause on each line a).	e of):	kcvD	ng, such as card	iac or respiratory a	errest,		Approximate Interval Between Onset and Death
rtificate be executed ng physicien and	rial-transit	Aedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d.		e of):	COPID					
death certif	res .	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□ Pregnant at ti 9□ Unknown	Fetal dea		topic pregnancy ther (specify)	,			Date of delive	ery Day Year
signed	d be	হ	Part II. Other significant conditions	contributing to death but	not resulting	j in the unde	rlying cause giv	en in Part I.		obacco use co Yes 2 No		ne cause of death?
The ete h	page 2 shoul	Completed							24a. Was auto perio	an 24b psy prmed? 2X No	D. Were auto prior to co death? 1 \(\sum Yes	psy findings available mptetion of cause of
Physician: this certific	o,	Be	25. Was case referred to medical examiner?	Hospital:			70#		eath (Check only	one)		
Phys r this	p la	<u>۲</u>	1 ☐ Yes 2 SNo 27. Manner of Death	1 Inpatient		Outpatient Time of	3 DOA Oth	4 Nursing	Home 5 ☐ Resi			y)
2 0	by the fune	Certification:	1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not 4 Homicide determine	(Month, Day) be 28e. Place of Injur	Year) y - At home,	Injury	M 1 🗆	k? Yes 2□No	28f. Location (Street and Nun		Il Route Number,
To the Hospital or A within 24 hours after To the Funeral Dire		edical Cert	29a. Certifier 12 Certifying F	Physician: To the best of eminer: On the basis of e	my knowled	ge, death oc	curred at the tin	ne, date and pla pinion, death oc	ce, and due to the	Cauca(s) and s	manner as si	tated.
othe ithin 2	omple	Med	29b. Signature and title of certifier	and manner state	ed.		29c. Licens			29d. Date sign		
- st	9		Nah				84	170 94				
TO			30. Name and address of person who		ath (Item 23a		nt)	Tues	SALS	hus	MD	21804

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 6 2006

32. Registrar's Signature

38340

		For State Registrar	•	State of Ma	arytano		artment of H rtificate of I		мептат ну	giene Rea. No.		
		Decedent's Name (/	First, Middle, Last)						2. Date of De	aath		3. Time of Death
Physicia /Medica		Richard	HC HC	ward	Pea	arson	Jr.		Novemb	er 13,	2006	2:20 a _M
Examine		4a. Facility Name (If no	ot institution, give str	reet and number)			4b. City, Town, or	Location of Dear	th	4c. Co	unty of Death	
		Charlotte						te Hall			. Mary	3
Funeral		5. Social Security Num	177			ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da	rth sy, Y ea <i>r)</i>	9. Birthp	lace (State or Foreign
Director		217-34-194	./	W 201	67	Yrs.			11/25/	1938	Vir	ginia
pur *	-	Usuel Residence of De 10a. State 1	ecedent 0b. County		10c. City	, Town or Lo	ocation				1	0d. Inside City Limits
Aaryli eho	ō	Maryland	St. Mary	re .			e Hall					1 StYes 2 □ No
288-1	Director	10e. Street and Number		5	Cite	ILIUCC	10f. Zip Code			10a Citizen	of What Coun	tn/?
be filed within 72 hours after deeth with the Maryland ital Hygiene. Id other then "natural", or iteme 23a or 28a-f show event, the Mudical Examinar must be notified at			rlotte Ha	11 Road			101. Zip 0000	20622		US		шу.
deeth me 2;	Funerai	11. Marital Status	12	. Was Decedent I	Ever in U.S	3. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No	0- 14.	Race - Americ	
or ite	בֿ	1 Never Married	2⊠ Marned	Armed Forces? 1 X Yes 2 □ N If Yes, Give	lo Nav	v	iiYes, specify Cuba 1 ☐ Yes 2 🔼 No	sn, Mexican, Puer Specify:	to Rican, etc.)		Black, White,	
raf.	ρ	3 ☐ Widowed 4 [Divorced	Year or Dates:		2	TU Tes Zenno	Specify:		Spi	ecify: Wh	ite
72 h natu	Completed	15 (Specify	5. Decedent's Educa only highest grade	ition completed)		(Give	dent's Usual Occup kind of work done	during most of wo	rking	16b. Kind o	of Business/Inc	dustry
dthin hen	gu	Elementary/Second		College (1-4or 5	+)	life.	DO NOT use retired	1)				
led w lygien her ti		12 17. Father's Name (Fin	44:44(- ()	-	-	Pai	nter	40. 14-15-1-1-1			inting	
nit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan partment of Health and Mental Hygiene. ortent: If item 27 is marked other then "natural", or iteme 23a or 28a-f show injury or other traumatic event, the Medical Exacidos must be notified at a.	Be		loward Pea	reon Sr					me (First, Middle		·	
d Me d Me mark matic	ို	19a. Informant's Nam				10b Mailie	ng Address (Street		Virgin			Codel
d 2 s th an trau			Pearson/w				E. Churc					C000)
Heal Heal tem		20a. Method of Dispos	sition		20b. Pl	ace of Dispo	sition (Name of	!	Date		on - City or To	wn, State
ages ent of nt: If i			Cremation 3 □Rei □ Other (Specify)	moval from State	Spr	ringhi	Tatory or other place. Y	11/1	16/06	Heb	ron, MI)
orten inju		21. Signature of Fune		1	Gc	rdens	Marie and Addre					sociation
Ped Fina		Marie	Af (6	mosm	> CF	SP	501 Snow	Hill Rd.	, Salis	bury,	MD 2180)4
		23a. Part1. Enter the shock, or heart f				. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between
Physician		Immediate Cause (Findisease or condition		Cond	i no							Onset and Death
/Medical		resulting in death)	(a.	Due to (or as	a consequ	ence of):	rhytts	11/2				
Examiner		Sequentially list condi	itions b.	Athero	SCIO	erot	ic Caro	Dovasi	ylar	dire	ase	
D #	Examiner	Sequentially list condi if any, leading to immi cause. Enter Underly Cause (Disease or inj	ediate ing	Due to (or as	a consequ	ence of):						
and -tran	каш	that initiated events resulting in death) Las	C.	Due to (or as	3 COREOGU	ionoa of):						
icate be executed physicien and s the burial-transit	a E	-	ı	240 10 (01 43	u 00113042	.onoo or,.						
ificate be executed g physicien and as the burial-transil	edlcal		d.									
		IF FEMALE: 23b. Was decedent pr	23	c. If yes, outcome	of pregnar	ncy				23d	Date of delive	n,
Jeath cert	ciar	in the past 12 mg	onths?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnancy Other (specify)					Day Year
by the de	Physician/N	9 Unknown	••	9□ Unknown								
res that igned to be det	by P	Part II. Other significa	ant conditions conti	buting to death b	ut not resu	lting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to th	e cause of death?
The law requires that the death cei ste hes been signed by the attendir page 2 should be detached for use	Pa	Chron	ic ob	Struci	Hve	- Air	way o	liteace	10	Yes 2□N	o 3 Prob	ably 4 □Unknown
awre s bee	Completed	Coron	DRY A	rtem	di	2001	e T		24a. Was		4b. Were autor	psy findings available
The law sete hes page 2 s	E O	Conoec	12'VP	40,001	E	Tailu	ve		auto perfe 1 Yes	ormed?	death?	npletion of cause of
icien: Th certificete ector, pag	0	25. Was case referred	to medical	TEWAT		y w	, _	26. Place of De	ath (Check only		10103	2010
Physicien this certifical director	70 B	examiner?	Ho	spital: 1 🔲 Inpatie	nt 2 🗆 8	ER/Outpatier	nt 3 DOA Oth	er: 4 🗌 Nursing I	Home 5 Res	idence 6 🗹	Other (Specify	Asst.
ng Ph fter th		27. Manner of Death 1 2 Natural	5 Pending	28a. Date of Inju	ry y Year)	28b. Time o	f 28c. Injur Wor	at k?	28d. Describe	how injury oc	curred	1174
endir Beth. or: A	atic	2 Accident	investigation 6 Could not be					Yes 2 □ No				
Hospital or Attending Physicien: 24 hours after deeth. Funeral Director: After this certificitely filled in by the funeral director,	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of Inju- building, etc	ury - At hos c. (Specify	me, farm, str ')	reet, factory, office			(Street and Ni wn, State)	umber or Rura	l Route Number,
spitai ours a nerai [filled		29a. Certifier 1	Carthying Physi	nien. To the heat	-6 mu les au	uladaa daab	h a second as the stee	4-1		()		
the Hospital	Medicai	(Check only 2 one)	☑ Certifying Physi ☐ Medical Examine	or: On the basis of and manner sta	examinat	ion and/or in	n occurred at the tin vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	date and pla	I manner as st ce, and due to	ated. the cause(s)
within To the Comple	Me	29b. Signature and the	le of certifier				29c. Licens	_		29d. Date si	gned (Month,	Day, Year)
(()) te	you.	M	-ar	_	D	5065	3		_	2006
8º48		30. Name and addres	s of person who con	pleted cause of d	eath (Item	23a) (Type,	Print) 6 1/2			- •		
1011.		5851	Dea	de c	niv	7 ch	ton R	TN -C	Den	le 11	ND :	2075)
Sta		31. Date filed (Month,	Dav. Year)	32. Registra	ar's Signat	ure						

DHMH 17 Rev 1/2001

State

Registrar

NOV 1 6 2006

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

			For	9			nd / Dep	artmen	t of F	lealth a		•		_ cg		000	1 1
			State Registrar 1. Decedent's Name (First, Mid	dle Last)			Ce	ertificat	e of	Death		2. Date of D	Reg. No.	21	JUb	3 8 3	
	Physici /Medio		James Henry (Novemi		8,	2006	4:40A	
	Examir		4a. Facility Name (If not institut	ion, give stre	eet and num	nber)		4b. City,	Town, o	r Location o	f Death		4c.		ty of Death		
	Funeral	į	Calvert Memor 5. Social Security Number	ial H			s. last birthday		nce]	Freder		8. Date of B	irth	C	alver		Foreian
6	Director		220-32-6912	1 💢 №	1 2□F	69		Months	Days	Hours	Min.	(Month, D July 1	ay, Year)	37_	Mary	ace (State or i try) land	
	iand ow		Usual Residence of Decedent 10a. State 10b. Coun	ty		10c. C	City, Town or I	ocation							11	Od. Inside City	Limits
	e Man	ctor	Maryland Cha	rles		Н	lughesv	ille								1 ☐ Yes 2	2 X No
	with th	Dire	10e. Street and Number					10f. Zip							What Coun	try?	
	death me 23	neral	15300 Debora		Was Dece	dent Ever in	U.S. 13		0637 dent of H	lispanic Orig	gin? (Spe	cify Yes or N Rican, etc.)	_		ce - Americ		
36	s after , or ite	y Fu	1 Never Married 2 M		Armed For 1 V Yes If Yes, Give	2 □ No e		1 ☐ Yes		an, Mexican Specify:	, Puerto i	Hican, etc.)		Speci	ack, White, i ifv:	hite	
Ş	2 hour ature!	ted b		ent's Educat		ites:	16a. Dec			ation					Business/Ind		
21215-0036	within 72 hours after death with the Maryland ene. Then "naturel", or iteme 23a or 28a-f ehow Ite Medical Exacultar must be motified at	Completed by Funeral Director	(Specify only high Elementary/Secondary (0-12		College (1-	-4or 5+)	Δ11† Off	edent's Usua e kind of wo DO NOT us Otive	rk done d se retired Tec	during most d) hnici:	of workii an	ng	Se	rvi	ce St	ation	
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ylan		To Be	Ashby Quade							Elno	ra Fa	arrell					
Maryland	s t and 2 should f Health and Mer Item 27 ie marke other treumatic		19a. Informant's Name/Relation Myrtle Quade/V	, , , , , ,	, Print)							Route Numi				Code)	
ē,	s 1 and if Healt item 2 other	3	20a. Method of Disposition			20b.	Place of Disc	osition (Nar	ne of	I	D	ate			- City or To	wn, State	-
Baltimore,	Peges ment of ant: if it ury or o		1		noval from S	State St	cemetery, cri						Bry	ant	own,	Maryla:	nd
Balt	permit. Peges Depertment of Important: if it eny injury or o		21. Signature of Funeral Service	00	chal	11	1	30195	Thr	ee No	tch I	Rd., C	harlo			, P.A., , MD 20	
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complicatest only one	tions that ca	esed the dea	ath. Do not e	nter the mod	le of dyin	g, such as	cardiac o	r respiratory	arrest,	-		Approximate Interval Betwee Onset and De	
į	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Due to (M p/o	ZJai	う c	as	ro	cy/	tome	1 0	7		20m	outer
	Examiner		Sequentially list conditions	b	000.0		Ain	e 7	50	sia	ch.						
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	₹	Due to (d	or as a conse	equence of):										
ó	ate be executed hysiclen end he burial-transit		that initiated events resulting in death) Last	c	Due to (d	or as a conse	equence of):										
	icate be physicies the bu	dlcal		d									-				
Rox	death certifical e attending phy id for use as th	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c.		come of pregr		□Ectopic pr	2000000				2	3d. Da	ate of delive	у	
o. B	0 0 9	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			ant at time of		Other (sp						М	onth	Day Ye	ar
л Р	E 28	þ	Part II. Other significant condi			ath but not re		underlying c	ause give	en in Part I.						e cause of dea	
Vital Records,	w requires to been signer should be	Completed	1910	<u> </u>	ran	er.						24a. Wa:				ibly 4 🗀 Uni	_
Ř	sicien: The law certiticate has t irector, pege 2 s	dmo									_	auto			prior to comdeath?	sy findings av apletion of cau	se of
VITa	Physicien: this certition ral director, I	Be	25. Was case referred to medic examiner?		-:				1 00		of Death	Check only					
0	Phy this raid	.T	1 Yes 2 No		28a. Date o	f Injury	28b. Time		8c. Injury	4 □ Nur		ne 5 Res)	
<u> </u>	를 곧 조 글	atlo	2	tigation	(Month	n, Day Year)	Injury	М	Work	k? Yes 2 □ N			. ,				
=	를 를 를 드	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	mined	28e. Place e buildin	of Injury - At I g, etc. <i>(Spec</i>	home, farm, s	treet, factory	, office		2	8f. Location City or To	(Street and wn, State)	Numi	ber or Rural	Route Numbe	NF,
	5 4 7 9	Medical C	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physici al Examiner	ian: To the la	sis of examin	nowledge, dea nation and/or i	th occurred	at the tim	ne, date and pinion, deat	l place, a h occurre	nd due to the	cause(s) a date and	and m	anner as sta and due to	ited. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certification	ier				290	. License	number			29d. Date	signe	ed (Month, E	Pay, Year)	
5	\sim		30. Name an oddress of erso	n who comm	oleted cause	of death (lte	om 23a) /Tvo	oPrint)	11.	595	21		11/	112	5/06	9ay, Year)	
{	V, ı		1 Fea	2	/1	o H	391 /c	el	Ro	1 #	7. 7	tredo	nic	le	ME	1 206	38
	Sta Registr		31. Date filed (Month, Day, Yea	2 0 2	32. Re	Colors Sign	nature	freel	e e								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		-	Cen	tificate of	Death		F	Reg. No.	JU	3834
Physic Medical Exar					Dobror				Date of De Month	Day Yea		3. Time of Death 1930 hrs
riculcai Exal	111116	Matthe 4a. Facility Name (if no		Lan street and numb	Rohrer		b. City, Town,	or Location of De		er 20, 2006 4c. County of	of Death	1930 1115
		128 Water La					Frederick			Frederic		
Funera Directo		5. Social Security Num 213-21-800	a =	i	Age (In yrs. la 18		If Under 1 Y Months D		rs. 8. Date of 8	irth (MM/DD/YYYY	9. Birth Foreign	nplace (State or West
Bircoto		Usual Residence of De		M 2 F		Yrs.			Jun 2	3,1988	Cou	^{ntr} Virginia
any		10a. State 10	b. County	1-	10c. City,	Town or Location						10d. Inside City Limits
Maryland 28a-f show any	i lie	Maryland	Frederic	CK		Frede						1 X Yes 2 No
0036 within 72 hours after death with the Maryland giene. yether "ham" natural", or items 23a or 28a-f she Madical Pynanicae must be notified at one	Director	10e. Street and Number 906 Motte	r Place				10f. Zip Code	21701		10g. Citizen of Wh U • S • A	Λ_{ullet}	try?
with th	2 2	11. Marital Status		12. Was Decede	ent Ever in U.S	6. 13. Was	s Decedent of R	Hispanic Origin? (Specify Yes or N	0- 14. Race	- Americ	an Indian, Black,
death or item	Funeral	1 X Never Married	2 Married	Armed Force 1 Yes	es? 2 X No			an, Mexican, Pue		White	e, etc.	
rs after rral",	<u>ع</u> ع	3 VVidowed		f Yes, Give Year or Dates:	completed)		Yes 2 X 1	No specify: pation (Give kind o	of work done	Specify:		Mhite
72 hour	pted	Elementary/Second		College (1-4		during mo	st of working I	ife. DO NOT use r	etired)	16b. Kind of Bu		-
vithin in ene.	Completed	11				Stude	ent				ucat:	ion
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	R C		rst, Middle, Last) Harry	V	Rohre	r		18.Mother's Na Kathle		Maiden Surname		
2121 ould be fill d Mental B		19a. Informant's Name	e/Relationship (Typ	pe, Print)		19b. Mailing	Address (Str	eet and Number of	or Rural Route Nu	mber, City or Tow	n. State.	Zip Code)
e, MD ; I and 2 shot Health and litem 27 is		Mrs. Kathy		Mother	1.00%					ck, Mary		
Baltimore, sermit. Pages I as Department of He Important. If its Important.	To Be Complete	20a. Method of Dispos 1 X Burial 2		Removal from	C1	lace of Disposi rematory or oth Olivet	er place)		Date	20c. Location -		, Maryland
Baltimore permit. Pages 1 Department of H Important: If it	ž.	4 Donation 5	Other Specify: ral Service nse	 e	16							, rial y land
Dep Dep		tokhm	in loke	PLADU) MOO7	06 106	Keeney East	& Bastor Church S	d P.A. I St. Frede	Funeral H erick. Ma	lome arvla	and 21701 Approximate Interval
Physicia /Medica		23 Fart I. Enter he of failure List only	disease, or complic one cause on each	cations that caus h line.	ed the death.	Do not enter th	e mode of dyin	g, such as cardia	c or respiratory ar	rest, shock, or hea	art	Approximate Interval Between Onset and
Examine	_	Immediate Cause (Fin or condition resulting i		langing ue to (or as a co	nsequence of	r						Death
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	iner	if any, leading to imme cause. Enter Underlyi	ediate Du ing Cause	ue to (or as a co	nsequence of)	:						
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7760, ficate be executed g physician and the burial at france			d	AMENDED								
8760, iificate be on physicia	Medi	IF FEMALE:		23c. If yes, out	come of pregn	ancv	-		_	23d. Date of	delivery	
OD	ian/l	23b. Was decedent pre past 12 months?	gnant in the	1 Live birth		2 Fet		Ectopic preg	nancy	Month	Da	y Year
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending room by Funeral Director: After this certificate has been signed by the attending the property of the	Physician/Medical	1 Yes 2 No	9 Unknown	9 Unknown		oth 5 Oth	er (Specify)			Ť		
P.O.	by P		ant conditions c	contributing to de	eath but not re	sulting in the ur	nderlying cause	given in Part I.		obacco use contril		
ords, P.C. w requires that as been signed be should be depart									- 1 Ye			bly 4 Unknown
COrc law re has be	۰,				 				auto	psy p		psy findings available mpletion of cause of
tal Rec cian: The l certificate l			to medical				26 Pla	ce of Death (Chec	1 🗸 Yes		✓ Yes	2 No
Vital I hysician: this certifi	5 c	examiner?		spital: 1 Inpa	atient 2 .	ER/Outpatient		Other	sing Home 5	Residence 6	Other: \$	Scene
Division of Vital Records, tal or Attending Physician: The law require is after death. After this certificate has been sided in by the finered interest nace 2 should be led in by the finered director nace 2 should a	n: T	27 Manner of Death		28a. Date of I	v Year)	28b. Time of In		jury at Work?	28d. Describe Subject har	how injury occurre	ed	
Sior Attend r death rctor:	catic	2 Accident	Pending Investigation	Nov 20, 20	06	1925 hrs		Yes 2 No				
Division pital or Attencours after deatheral Director:	Certification:	3 ✓ Suicide 6 4 Homicide	Could not be determined	⁷		me, farm, stree / Rowhous		bullaing, etc.	or Town.			I Route Number, City
Divisior Hospital or Attend 24 hours after death : Funeral Director			ertifying Physician					date and place, a				
Division To the Hospital or Attent within 24 hours after death To the Funeral Directorn commulerely filled in by the	Medical	one) 2 Me		On the basis of e and manner state		d/or investigati			d at the time, date			
	2	29b. Signature and title	a of certifier	\mathbf{v}			- 1	nse number C.M.E.		29d. Date signe		
		30. Name and address	of person who co	mpleted	R. Mun	-24/				_ inovember 2	_ 1, _ 200	
H		Theodore M. H		_	Medical Ex		111 Penn S	Street, Baltimo	ore, MD 2120	1		
	State	31. Date filed (Month, I	Day, Year)	32 Regis	trar's Signatur	lage	1.0					<u> </u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-I per ME 1861,11729/06dhb

State of Maryland / Department of Health and Mental Hygiene ME 1861,11729/06dhb

Certificate of Death

Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Robinson Month Physician Velson Nou 08 06 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Charles La Plata
If Under 1 Year | If Under 24 Hrs. ivista entel Medica 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2□F Hours 577-24-954 Usual Residence of Decedent Yrs Director MARYLANCI 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYIANC (10e. Street and Number Directo Idor 10f. Zip Code 10g. Citizen of What Country? 2060)eira Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Black other then "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Buy Const Abor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Keisci) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Robinson Macyland 20601 JON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: if it eny injury or o once. 1 denotation 3 □Removal from State Thomas Chuech 4 □ Donation 5 □ Other (Specify) MARYIANCI 22. Name and Address of Facility Adams FUNERA Home P.A 21. Signature of Funeral Service Licenses lu 20605 Aguasco Road Aguasco, Maryland 20608 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Fracture Right Lip Physician LOUIS /Medical Due to (or as a consequence of): Alzkeineis! Years Examiner dispas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner TO RY MEDICAL EXAMINE The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death -Month Day Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Certification: To Be Completed by Least disease HYPEHERSIVE 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No esoplagitis retention, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/2 No 1 ☐ Yes 2 ☐ No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 **∑X** es 2 √ 1 _npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 ☐ Pending subject fell from standing 1 Yes 2 No investigation 11/04/2006 **Unknown**^M Director: / 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Magnolia Dr., LaPlata, MD thin 24 hours after do the Funeral Direct filled in by 4 Homicide at Nursing home 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 R. Sindleum 11/8/06 -61614 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Waldorf, Ma K. Sindhwardi 11350 Pembrooke 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

NOV 2 9 2006

ORIGINAL

			1 - For State Registrar	State	of Maryla		artment o		and Mental	Hygie Reg.	211116	38344
	Physici		Decedent's Name (First, Middle	.,	gie Batt	le Smith)		2. Date Mont		Day Yeer	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution			ic Office		n, or Location of	of Death	INOV	1, 2006 4c. County of De	
	LAGIIII	iei	South River Hea	lth & Rehabi	litation Cer	nter		Edgew			1.	e Arundel
	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Ye			of Birth	9. B	irthplace (State or Foreign Country)
	Director		088-16-7802	1 ☐ M 2 💢 F	10	3 Yrs.	Months Da	ys Hours		h, Day, Ye av 12, 1		Georgia
_	2		Usual Residence of Decedent									
	nylar phow	_	10a. State 10b. County		10c. C	City, Town or Lo	ocation					10d. Inside City Limits
	9 W	ct		ne Arundel				Harw	ood			1 Yes 2 XNo
	within 72 hours after death with the Maryland ene. Than "natural", or items 23s or 28s-f show In Medical Examinar must be notified a	Funeral Director	10e. Street and Number				10f. Zip Cod			10g.	Citizen of What C	,
	ah v	<u>e</u>	4689 Sands Road					2077				S.A.
	er de	nue	11. Marital Status	Armed	cedent Ever in Forces?		Was Decedent of If Yes, specify C	of Hispanic Ori Juban, Mexican	gin? (Specify Yes i, Puerto Rican, etc	or No- c.)	14. Race - An Black, Wh	nerican Indian, ite, etc.
9	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	if Yes, (1 ☐ Yes 2 💢	No Specify:			Specify: B	lack
2000	hour fural			l's Education	Dales.	16a Dece	dent's Usual Oc	cupation		166		
Ċ	in 72	jet	(Specify only highe	st grade completed		(Give	kind of work do DO NOT use re	ne durina most	t of working	100	. Kind of Busines	Sindustry
7	the the	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)			eautician			Self-E	mployed
9	filed Hyg other ant,	BeC	17. Father's Name (First, Middle,	Last)				18. Mothe	r's Name (First, M	liddle, Maid	den Sumame)	
<u>a</u> 20	id be ental kad o ic eve	To B		Henry	Goldwire					Isabe	lle Jones	
<u></u>	nit. Pages 1 and 2 should be filed within turnent of Health and Mental Hygiene. orent: If Item 27 is marked other than Injury or other traumatic avant, tha Ma-	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Str	et and Numbe	or or Rural Route N	lumber, Ci	ty or Town, State,	Zip Code)
Ĕ	and 2 salth a n 27 is		Margo Easton/Frien	d		6228	Franklin G	ibson Roa	ad Tracy's La	nding,	MD 20779	
กั	s 1 a f Hei f Hei ltem othe		20a. Method of Disposition			Place of Dispo	sition (Name of	n/aca)	Date	20c	. Location - City o	r Town, State
	Page ent o nt: # ry or		1 🗷 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		m State	•	natory of ourse. Nemorial Ga	· 1	11/17/06		Duni	kirk, MD
ащно	permit. Pages Department of i Important: If Its any Injury or o ance.		21. Signature of Funeral Service				2. Name and Ad	dress of Facilit				
Ď	Depa Impo		Deadyn a	Servel			000700710	Funeral	lome ch Road Prir	ce Fre	derick MD S	20678
	cate be executed /Medical Examiner sthe burial-transit	dical Examiner	23a. Part1. Enter the isease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due t	o (or as a conse	equence of): Output Description Descripti	4ryh	ythm			litease	Approximate Interval Between Onset and Death
.O. DOX 00	To the Hospital or Attending Physician: The law requires thet the death certificat within 24 hours effer death. within 24 hours effer death. completely filled blactor: After this certificete hes been signed by the ettending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □ Live	outcome of pregotion to the property of the pr	tal death 3	⊒Ectopic pregna] Other (specify,				23d. Date of do	blivery Day Year
cords,	quires then signed and be de	þ	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	nderlying cause	given in Part I.		Did tobacc		to the cause of death? Probably 4 @Onknown
	The law re ete hes be page 2 sho	Completed	Renal	insuit	i'ci'er	ncy			:	Was an autopsy performed /es 2 12	? death?	utopsy findings available completion of cause of
N I G	stan: artific ctor,	Be (25. Was case referred to medical examiner?					26. Place	of Death Check	only one)		
5	Physicien: r this certific ral director,	ဥ	1 Yes 2 No	Hospital: 1	Inpatient 2	☐ ER/Outpatier	II 3 DOA		rsing Home 5	Residence	6 □Other (Sp	ecify)
=	ng P fler t inera		27. Manner of Death 1 ☑Natural 5 ☐ Pendir		e of Injury onth, Day Year)	28b. Time of Injury	28c. li	york?	28d. Desc	ribe how in	njury occurred	
202	Attending r death. actor: After by the fune	cati	2 Accident investi	gation			M 1	☐Yes 2☐N	No			
	tal or Att rs efter d al Diract ed in by	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 289. Pla	ce of Injury - At Iding, etc. (Spec	home, farm, str cify)	eet, factory, offi	C O	28f. Locat City o	ion (Street or Town, St	and Number or F ate)	Rural Route Number,
	the Hospital or hin 24 hours effe the Funeral Dir npletely filled in	Medical	29a. Certifier 1 ☐ Certifyir (Check only 2 ☐ Medical one)	ig Physician: To the Examiner: On the and ma	he best of my kr basis of examination of the basis of examination of the basis of examination of the basis of	nowledge, death nation and/or in	n occurred at the vestigation, in m	time, date and y opinion, deat	d place, and due to th occurred at the t	the cause time, date a	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifie		(29c. Lic	ense number	150	29d. l	Date signed (Mor	
) lugi	w.c	· 20	-ara	- 2	150	653		11-13	-2006
	1		30. Name and address of person	who completed ca	use of death (Ite	em 23a) (Type,	Print) Gy	AW -	C. SU	RAN	VA	
	7		5851 - D	ecele	chu		on Y	Road	Do	ele	m	0 20757
	Sta		31. Date filed (Month, Day, Year)	1 3 2006	Registra Sign	nature	1.00	9 0				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0.0.5

			1 - For State Registrar	State of Ma	ıryıanu	Ce	artment of Fi rtificate of I	ieaith and i Death		leg. No.	Ub	38345
			Decedent's Name (First, Middle, L.	ast)	•				2. Date of Dea	th	.,	3. Time of Death
	Physici /Medio		Virginia	Alberta		Shed	ckells		November 1	er 12,	2006	5:00 A M
	Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, or	Location of Death			y of Death	
		П.	Calvert County					Frederic			lvert	
1	Funeral			- T-0 -	9 (In yrs. las 83	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	·. Year)	9. Birtho	place (State or Foreign
	Director		215-44-3200 Usual Residence of Decedent		03	113.			Apr. 21	, 1923	Mar	yland
	/land		10a. State 10b. County		10c. City,	Town or Lo	ocation				1	Od. Inside City Limits
	Mar Mar	tor	MD Calv	ert			Huntingt	town				1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of		ntry?
	after death with the Maryland or Itema 23e or 28e-1 ehow mitter mat be notified at	rai	4250 Old Town R					539		USA		
		Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla	ce - Americ ick, White,	
3	hours after turni', or ite	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	10		1⊡Yes 2 X No	Specify:		Specia	^{fy:} ₩h	nite
Maryland 21215-0036	be filed within 72 hours ital Hygiene. d other then "natural", event, ine Modical Exp	ted	15. Decedent's	Education		16a. Dece	dent's Usuat Occup	ation		16b. Kind of E		
212	within 72 ene. then "ne!	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	kind of work done of DO NOT use retired	during most of work d)	ang			
7	filed wi Hygien other th	ပ္ပ	12			offic	e managei					oly company
	tal H d oth	Be	17. Father's Name (First, Middle, La					18. Mother's Nam				
$\frac{8}{5}$	should be nd Menta marked matic ev	10	James Albert 19a. Informant's Name/Relationship	Dowell		105 14-0	ng Address (Street	Bertha	Marie	Turn		· Co do l
<u>8</u>	2 a = 2		Peggy Marie Tho		hter		_				, State, Zip	Code)
	s 1 and f Health Item 27 other to		20a. Method of Disposition	in sorr, daug			esition (Name of matory or other place		Date	20c. Location	- City or To	own, State
ē	Pages nent of ant; If It ary or o		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		_	_	Cemetery		5-2006	Huntin	atowr	n, MD
Baltimore,	# 문원을 .		21. Signature & Furthral Service Lic				2. Name and Addres				_	•
Ď	Depa impo eny ii		William	B. () L	0		Rausch	Funeral H	Home, P.	A. Owir	ngs, l	MD 20736
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each lin	the death.	Do not en	er the mode of dyin	g, such as cardiac	or respiratory are	rest,		Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition				FREB				25	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as								
	- Adminior	_	Securitieity list conditions	b. Due to (or as	a conseque	nce off:						720
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	300 10 (01 20	a concoque							
,	ificate be executed g physicien and as the burial-transit	Exal	that initiated events resulting in death) Last	Due to (or as	a conseque	nce of):						
68760,	te be ysicie	edicai		d								
	÷ 0,0		IE EENALE.									
P.O. Box	The law requires that the death certificate site has been signed by the attending physoage 2 should be detached for use as the	ician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth			Ectopic pregnancy	,			ate of delive	ery Day Year
0	the a	sici	1 ☐ Yes 2 No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time of dea	th 5	Other (specify)				5,111	Day Tour
	that the bod by detac	by Phys	Part II. Other significant conditions	s contributing to death be	ut not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use con	tribute to the	he cause of death?
Vital Records,	uires sign Id be								1 🗆 Y	es 20No	3 □ Prob	pably 4 Unknown
Ö	w require been sig should t	Completed							24a. Was a	an 24b.	Were auto	psy findings available
Re	he lav e has age 2	Ë							autop	med?	death?	mpletion of cause of
a		0	25. Was case referred to medical	1				26. Place of Dear		2 No	1 ☐ Yes	#P 140
>	Phyeician: The la rthis certificete has ral director, page 2	To B	examiner?	Hospital: 1 ☐ Inpatie	nt 2 E	R/Outpatie	nt 3 DOA Oth	er: Nursing He	ome 5 Resid	ence 6 □Ot	her (Specif	y)
0	Attending Physician: r death. sctor: After this certific by the funeral director.		27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 2	8b. Time o	Wor		28d. Describe h	ow injury occu	rred	
<u>s</u>	tendi leath. tor: A	cati	2 Accident investigat	the -				Yes 2 □No	004 1 10			
Division of	or At after of Direction by	Certification:	4 Homicide determine		. (Specify)	ie, farm, st	reet, factory, office		City or Tow		ber or Hura	al Route Number,
	ours a		29a. Certifier Certifying	Physician: To the best	of my know	edge, deat	h occurred at the tin	ne, date and place.	and due to the	ause(s) and m	anner as s	tated.
	1 24 h	Medical	(Check only 2 Medical Ex	caminer: On the basis of and manner sta	examination	n and/or in	vestigation, in my o	pinion, death occur	rred at the time, o	date and place,	, and due to	the cause(s)
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	M	29b. Signature and title of certifier		15	>	29c. Licens	e number	- '	29d. Date signe		
				mati	(2	2547	>	111	131	06
	D		30. Name and address of person wh					205 - 1			ME 01	0.70
			Mukesh Mathur,	M.D., 110 F			aa, Ste.	305, Prin	ice frede	erick,	MD 20	אל סע
	Sta Regista						Sparke					
					ALCON DE	~	La hande					

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 6 38347 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** James Eugene Shook NOVEMBER 18 2006 2:02 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year May 7, 1939 Birthplace (State or Foreign Country) **Funeral** 1 X M 2 ☐ F 171-32-8092 67 Yrs. Director Pennsy Ivania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or then "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 X No St. Mary's Maryland Mechanicsville 10e. Street and Number 10g. Citizen of What Country? 26729 Marion Drive 20659 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 Sr. Vice President Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fi Heelth and Mental H Iom 27 Io marked ot ဂ္ Raymond A. Shook Eleanor Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Ann Shook / Wife 26729 Marion Drive, Mechanicsville, Maryland 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Depertment important: If any injury or pace. Charles Memorial Gardens 22, 2006 Leonardtown, Maryland 21. Sign vure of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC **Physician** DYSRHYTAMIO Minu tes /Medical Examiner arpio Vascula- Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physicien and s the burial-transit The law requires that the death certificate be executed Exam resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760. Medical Certification; To Be Completed by Physician/Medical attending physic IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No certificate has been si rector, page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner?

1 Yes 2 No director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 32 DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient this within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State Registrar

FUCENE SHOOK

ARTHURGRO

DHMH 17 Rev 1/2001

Registrar

JACK SALISBURY

DHMH 17 Rev 1/2001

SIMMONS

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryland / Dep		Mental Hyg Re	iene _{eg. No.} 20	05 38350
	Physici /Medic Examin	al	Ardie Lee Smith, 4a. Facility Name (If not institution, give s Harford Memorial	treet and number)	4b. City, Town, or Location of Death Havre de Grace	Month Nov.	17 20 4c. County of Harf	
E	Funeral Director		5. Social Security Number 212-32-0423 6. Sex 103 Usual Residence of Decedent	7. Age (In yrs. last birthday 7 1 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day	Year) 1935	9. Birthplace (State or Foreign Gountry) Maryland
	saler death with the maryland ", or iteme 23a or 28a-f ehow raminer must be notitied at	rector	10a. State 10b. County Maryland Cecil 10e. Street and Number	10c. City, Town or L North E		11	0g. Citizen of W	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
4	me 23a or	Funeral Directo	1281 W. Old Philad		21901 Was Decedent of Hispanic Origin? (Slif Yes, specify Cuban, Mexican, Puert		USA 14. Race	- American Indian,
	within 12 hours after one. then "naturel", or itse	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 [7].No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specity:		Specify:	white, etc. White
-לוצוג	giene. er then "nati	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	CORRECT (1:401.5+)	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired) PENTER	king	16b. Kind of Bus	
Maryland 21	nould be filed of Mentel Hy narked other natic event.	To Be C	17. Father's Name (First, Middle, Last) Ardie Lee Smith	Of the second	Irene A	ne (First, Middle, A nn Kenned	ly	
	s I and 2 st f Health and ftem 27 le n other traun		19a. Informant's Name/Relationship (Ty) Norma Smith/Wife 20a. Method of Disposition	1281 20b. Place of Disp	ling Address (Street and Number or Ru W. Old Philadelpi cosition (Name of practory or other place)	hia Road	North E	
=	permit. Pages Department of Important: If it any njury or o		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Smature of uneral Service License	R T Foar	d Funeral Home, P. 122. Name and Address of Facility R 111 South Queen S			
760,	Medical Medica	dicai Examiner		cations that caused the death. Do not end of each line CICHO CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF T	NAL HEM LS PA	or respiratory arre RERIC SE	est,	Approximate Interval Between
Box	e attending of for use e	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		☐Ectopic pregnancy ☐ Other (specify)		23d. Date Mont	of delivery Tear
Records, P.	ine law requires the the ore to the has been signed by the bage 2 should be deteched	ρ	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	_	bute to the cause of death?
	ate has	e Completed	DE Western de la Constitución de				pr ned2 de No 1 (ere autopsy findings available for to completion of cause of path? ☐ Yes 2 No
5 5	certificaling	0	25. Was case referred to medical examiner?	ospital:npatient 2 - ER/Outpatie	Other	th Check only one		
Division of	Attending Frystolan: r death. ector: After this certific by the funeral director,	ation: To	27. Manner of Death 1 Statural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 2Bb. Time Injury		ome 5 Reside 28d. Describe ho		
DIVIS		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town	, State)	r or Rural Route Number,
	vithin 24 hours efter or the Funeral Dilliconpletaly filled in	Medicai	29a. Certifier (Check only one) Certifying Physical Examination and title of certifier	ician: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place nvestigation, in my opinion, death occu	rred at the time, da	ate and place, ar	ner as stated. nd due to the cause(s) (Month, Day, Year)
,	7		· David C	Bruk, M,	A 2003694	No Co	OVEMS!	IR 17,2006
	Sta Begiste		31. Date filed (Month, Day, Year)	M.D. SOI CON	DOD 3694 D. Print) ALR OLD MI MH UNION AVEN	UE, HA	ME DE	GRACE 20078

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene) For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10:45Am **Physician** Steffens Dietrich Henry November 14.2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner La Plata Charles Civista Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 84 216-16-0134 1**X** M 2□ F Yrs. April 11.1922 Maryland Director Usual Residence of Decedent ified within 72 hours after death with the Maryland I Hygiene.
other than "natural, or items 23a or 28a-1 ehow 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Bryantown Charles MD Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20617 USA 5550 His Lordship Place 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Land Surveyor 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Professional Land Surveying 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othing any liquy or other traumatic event ones. Be Marie Mueller Louis Henry Steffens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret Steffens/Wife P.O. Box 28, Bryantown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Rest Cemetery 11/17/06 La Plata, MD 21. Signatur of Funeral Service Licensee M00945 22. AREHART-ECHOLS FUNERAL HOME, P.A. St. Mary's Ave. La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heart Due to (or as a consequence of) Failure **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner ettending physiclen and for use es the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the 6 d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy lindings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 2 No certificete 1 Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Anpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ٩ this s after death.

I Director: After this of in by the funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 X Natural 28d. Describe how injury occurred Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funarai I filled i 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number anna 0005291 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Harring, M.D. 102 Centennial Avenue La Plata, MD 20646 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 🖔 38352 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month **Physician** NOVEMBER 18 RITA MAXINE SMITH 2006 2203 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2図 F Yrs Director 153-32-3286 1942 64 MISSOURI Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b Counts 10d, Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 21 No Director MARYLAND WASHINGTON BOONSBORO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7625 MOUNTAIN LAUREL ROAD 21713 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 21X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL RECORDS SUPERVISOR HEALTHCARE SYSTEM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HARVEY H. WILDER NAOMI HUMPHREY ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 is 1 WILLIAM L. SMITH/SPOUSE 7625 MOUNTAIN LAUREL ROAD BOONSBORO, MD 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ⁴ 4 ☐ Donation 5 Other (Specify) 11/22/2006 BOONSBORO CEMETERY BOONSBORO, MARYLAND 21. Signature of Funeral Service Li 22. Name and Address of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Part I. Enter the disease, or son shock, or heart failure. List only Approximate Interval Between Onset and Death implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Immediate Cause (Final disease or condition resulting in death) rosele Priysician 42925 /Medical Due to (or as a consequence of): Examiner vier Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as a consequence of): Examiner death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 ☐ Yes 2 Z No 1 Inpatient 2 A R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 8b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signatule and title of certifier 29d. Date signed (Month, Dav. Year) 6516 completed cause of death (Item 23a) (Type, Print) person who OH-17 01 SON 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** M 1:28 15A SISK NOVEMBER 19, 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE INIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F 217-82-7198 39 March 10,1967 Maryland Director Usual Besidence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 28a-f show notified at XXYes 2 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or must be 21740 USA 21 Elizabeth St. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinen once. 1 Never Married XXMarried 1 ☐ Yes 2 No Specify. þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Cook Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Lee Obitts Delores JoAnn Socks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Sisk - Husband 21 Elizabeth St. Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition

✓ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Nov. 25.2006 Hagerstown, Maryland Rose Hill Cemetery 21. Signatur Funeral Service DSDOTTHE FUTTER FITH HOME, P.A. 21795 425 S. Conococheague St. Williamsport, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS DAYS **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner FEMORAL ARTERY THROMBUS WEEK 16H Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is littled as each Examiner that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1⊟ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1-Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 1 Natural 2 ☐ Accident (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Hospital or Attending Physiclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 24 hours a

Baltimore, Maryland 21215-0036

JH-2

State Registrar

within 2

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) NOVEMBER 19, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARC F. BRAZIE, MD STREET, BALTIMORE, MARYLAND 22 SOUTH GREENE

31. Date filed (Month, Day, Year) NOV 20

29b. Signature and title of certifier

29a. Certifier

Medical

32. Registrar's Signature

Joseph Leon Thompson imore, Maryland 21215-0036

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Physicia		Decedent's Name		Joseph Le	eon T	hompsor	 1			2. Date of Month Nove	Death	Day	Year 2006	3. Time of Death
/Medic Examin		4a. Facility Name (I	f not institution	give street and nu				4b. City, Town, or E1kton	Location of Dea	ath		4c. Coun	ity of Death	
Funeral Director		5. Social Security N 215-30-6	lumber 583	6. Sex 1 Mg M 2 □ F	7. Age (In	n yrs. last birth Yı		If Under 1 Year Months Days	If Under 24 Hi Hours Min	n. (Month,	Day, Ye	918	Cour	place (State or Foreign htry) yland
aryland show	7	Usual Residence of 10a, State	10b. County		10	c. City, Town		cation					1	0d. Inside City Limits 1 ☐ Yes 2 🏋 No
with the M a or 28a-f be notified	Directo	Maryland 10e. Street and Nur				Elkto	on	10f. Zip Code 21921			10g.		f What Cour	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or othar traumatic evant, I've Medical Evantical must be notified at once.	by Funeral	21 East 11. Marital Status 1 Never Marri 3 Widowed	ied 2 ∏ Marri	12. Was Dec Armed F ed 1 \(\triangle Yes If Yes, G	orces? 2 X No live	r in U.S.	li	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? In, Mexican, Pue Specify:	(Specify Yes or erto Rican, etc.)	No-	14. R	ace - Americ lack, White,	can Indian, etc.
ithin 72 hourse. i.e. i.e. i.e. i.e. i.e. i.e. i.e. i	Completed b		15. Decedent cify only highes	t grade completed,			Give life. [lent's Usual Occup kind of work done on OO NOT use retired	during most of w	rorking	A	utom	Business/Inobile	,
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and 2 shou ealth and M m 27 is mar	 	19a. Informant's Na	ame/Relationsh	nip (Type, Print)				g Address (Street	and Number or i	Rural Route Nu		•		
Pages 1 and nent of Hermant: If Item		20a. Method of Disp 1 X Burial 2 ` 4 □ Donation	☐Cremation	3 □Removal from	t t	cemetery	, cren	sition (Name of natory or other place Cemetery		ember 2006			n - City or To	
permit. Departn Importa any inju		21. Signature of Fu	uneral Service I	s thuk	20		Hi 10	Name and Address Cks Home 3 W. Stoo	ss of Facility					
Physician		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List (Final	complications that only one cause on	caused the each line.	Shock	ot ente	er the mode of dyin	g, such as cardi	ac or respirato	y arrest,			Approximate Interval Between Onset and Death UMR Num
/Medical Examiner bhysician and s the prival-transit	Ical Examiner	Sequentially list co if any, leading to in causs. Enter Unde Cause (Disease or that initiated events resulting in death)	nmediate only no only only no only no only no only only only only only only only only only only only only only	c	Proce (or as a co	onsequence of consequence of								Unknavn.
ath certif attending for use a	by Physiclan/Medl	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No		birth 2 [gnant at tim	Fetal death		Ectopic pregnancy	,		_		Date of delive	ery Day Year
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al or Attendi s after death. al Director: A ed in by the fu	Certification;	3 Suicide 4 Homicide	6 Could a determ	28e. Place build	ce of Injury ding, etc. (- At home, farr Specify)	m, str	eet, factory, office			n (Stree Town, S		nber or Rura	al Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one)	2 Medical		ne best of n basis of ex inner stated	amination and	death /or in	vestigation, in my o	pinion, death oc	ce, and due to curred at the tir	ne, date	and place	e, and due to	o the cause(s)
To t To t	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yea 11. 17.06. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Sach Ev MD 118 North of Stuff 3B Elector MD 21921 31. Date filed (Month, Day, Year) 32. Registrar's Signature												
6		30. Name and add	ACHD (who completed cau	118	Nosk	Sype.	Suite 3	BER	Etan D	102	192/	′	
Sta Registr		31. Date filed (Mor	NOV 3	0 2006	ragistrar's	Signature	1	parki						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death nay Month Year **Physician** 1904 WILLIAM LEROY THORNTON 11 15 00 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WICOMICO PENINSULA REGIONAL MED. CENTER SALISBURY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** 1∏ M 2□ F Months Days 230-60-9994 MAY 17,1939 VA Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director ACCOMACK HALLWOOD VA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23359 28227 GROTON TOWN ROAD USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 72 hours after 1 Never Married 20 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. 12 FARMER AGRICULTURE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Pages 1 and 2 should be fill ment of Health and Mental H: ant: If item 27 is marked oth Be WILLIAM LEE THORNTON EDNA TAYLOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MELINDA DAWN THORNTON (WIFE(PO BOX 222 - HALLWOOD, VA 23359 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot ₩ Burial 2 Cremation 3 Removal from State DOWNING'S CEMETERY NOV.18,06 OAK HALL, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THORNTON FUNERAL HOME PO BOX 264 - 24183 CHADBOURNE ST. PARKSLEY, VA 23421 CARL U. THORNTON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Small Cell Lung Cancer Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Por in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9∏Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy perform certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 1 🗹 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

within 24 hr.urs after death

To the Funeral Director:
completely filled in by the

85-39

State Registrar

31. Date filed (Month, Day,

1.0. Zimmy TAYLOR

2006

Year)

NOV 22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E CAPPOIL ST.

SHLISKINY MO

		•	For State Registrer	State of	Marylar		artment of H rtificate of L			giene	U b	38356
	Physicia	an l	1. Decedent's Name (First, Middle	, Last)					2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic	al	Clyde		арр		45 Ch T			er 19, 2		6:30 p M
	Examin	er	4a. Facility Name (If not institution, Charlotte Hall	•				Location of Death		4c. County	of Death Mar	w.t.c
	Funeral		5. Social Security Number			last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	b		olace (State or Foreign ontry)
	Director		242-24-0037	1 1 M 2 □ F	85	Yrs.	Months Days	Hours Min.	(Month, Da)	(29, 1921)	Nort	h Carolina
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation		-		1	10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show rimust be notified at	tor	Maryland Char	1es		Waldor	f					1 ☐ Yes 2 📉 No
	or 288	Director	10e. Street and Number	100		WGIGOI	10f. Zip Code			10g. Citizen of	What Cour	ntry?
	23a c	rai	2420 Pinefield	Road			206	501		U S	A	
	er des	Funeral	11. Marital Status	12. Was Dece	ces?	J.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	- 14. Rad Bla	e - Americ ck, White,	can Indian, etc.
Ş	il', or	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 Yes If Yes, Giv Year or Da	Θ		1 ☐ Yes 2½ ∏ No	Specify:		Specif	/: B1	ack
2-003d	r2 hou	ted	15. Decedent (Specify only highes	's Education		16a. Dece	dent's Usual Occupa	ation	v.n.a	16b. Kind of B		
7	ithin 7	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)		kind of work done of DO NOT use retired)	(ing			
777	lied w lygier ther th		12 17. Father's Name (First, Middle, I	(251)			Welder	18. Mother's Nam	e (First Middle	Self I		yed
/land	ould be filed within 72 hours efter Mental Hygiene. arked other than "natural", or Ite atic event, the Madical Examina	o Be	James	Trapp				Minnie	io (i nat, milatio,	Alexand		
	2 should and Men Is marks sumatic	2	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Numbe	er, City or Town,	State, Zip	Code)
, Mai	s 1 and 2 should be filed within 72 hours efter death with the Marylan I Health and Mental Hygiene I Health and Mental Hygiene I Health and Mental Hygiene I Health and I Heal		Odette Nixon/Da	ughter			Pinefie1		Waldorf	, MD 206	501	
ore ore	Pages 1.		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 □Removal from S	20b.	Place of Dispo cemetery, crer	sition (Name of natory or other plac	e)	Date	20c. Location -	City or To	own, State
аппо			4 □Donation 5 □ Other (Sp	pecify)	В		ld-Echols					
מ	permit. Depertr Importa		21. Signature of Funeral Service I	al t	moo	641	Name and Address Prinsfield .O. Box	d-Echols 128, Chai	Funeral	aII, Ma	P.∆ ryIar	nd 20622
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the dea	th. Do not ent	er the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	Prest	ate co	meen					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	meen nellitu					
		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (Diabe or as a consec	quence of):	nellitu	- \$				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
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08/00,	tificate be executed g physician and as the burial-transit	edical		d								
	certifi nding use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn	ancy				23d Da	te of delive	PLV.
DOX	death e atter	Physician/N	in the past 12 months?	4□Pregn	irth 2 ☐ Feta ant at time of o		Ectopic pregnancy Other (specify)			Mo		Day Year
5	at the by the	hys	9 🗆 Unknown	9□ Unkno	-				T			
ds, I	w requires that the death cert been signed by the attendin should be detached for use	þ	Part II. Other significant condition	ns contributing to de	ath but not re	sulting in the u	nderlying cause give	en in Part I.		obacco use cont ′es 2 □ No		pably 4 Dinknown
ecords	law req as beer 2 shou	Completed							24a. Was	an 24b.	Were auto	ppsy findings available
Ľ	o = 0	E O			***				autop perfor 1 Yes	rmgd?	prior to coi death? 1 □ Yes	mpletion of cause of
VII	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					26. Place of Dea				
5	hys this al dii	၉	1 ☐ Yes 2 DNo 27. Manner of Death			ER/Outpatier		4 Nursing H	ome 5 Resid			y)
	ding h. After fune	tlon	1 Natural 5 Pending	9	h, Day Year)	28b. Time of Injury	Work	/at <br Yes 2 □ No	28d. Describe h	low injury occur	rea	
UNISION	or Attending after death. Director: After in by the fune	fica	2 Accident investig 3 Suicide 6 Could r 4 Homicide determine	not be 28e. Place	of Injury - At h	ome, farm, str	eet, factory, office				er or Rura	al Route Number,
5	P the c	Certification:	4 Homicioe	Duildir	ng, etc. (Speci	(V			City or Tow	m, State)		
	24 h	ca	(Check only 2 Medical	g Physicien: To the Examiner: On the ba and mann	isis of examin.	ation and/or in-	vestination in my or	ninion death occur	red at the time /	and place	and due to	the cause(s)
	To the within 2 To the complex	Me	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, A. Wael Hazeth mn. NO 100 Hospital Rd 29c. License number 29d. Date signed (Month, A. Wael Hazeth mn. NO 100 Hospital Rd 29c. License number 29d. Date signed (Month, A. Wael Hazeth mn. NO 100 Hospital Rd 29c. License number 29d. Date signed (Month, A. Wael Hazeth mn. NO 20d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Egistrar's Signature									
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X	5		30. Name and address of person	who completed caus	e of death (Ite	m 23a) (Type,	Print)	0	Tender	rick, r	10 2	20678
\ 			A. Wall Hage TI	1mm, MO	100 gistrar's Sign	HOSP 1	tal Ka	prince	r reside			
	Sta Registr	te ar≀	NOV 2	2 2006	frame.	N A	made					

•			For State Registrar	State of N	/larylan	•			ealth a Death		-	giene Reg. No.	2006	3835
			1. Decedent's Name (First, Middle, Las	st)					_		2. Date of De Month	ath Day	/ Year	3. Time of Death
	Physicia /Medic		RICHARD M	. WELV	ER								20 200	6 0737AM
	Examin		4a. Facility Name (If not institution, give	street and numbe	r)		4b. Cily	, Town, or	Location	of Death		4c.	County of Dea	
			DHIVERSITY OF M					Tim		CIT				H/A
E	Funeral Director		5. Social Security Number 6. S 160-36-3731 1	ex 7.7 (XIM 2□F	Age (In yrs.	last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Dec. 31	th ly. Ye <i>ar)</i> 194	9. Bir	thplace (State or Foreign
	D .	-	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ncation							10d. Inside City Limits
	death with the Maryland me 23a or 28e-f ehow	5	Pa. Adams			•	ervi	110						1 □ Yes 2 No
	the N	Director	10e. Street and Number			DIG.	_	p Code				10g. Citi	izen of What C	ountry?
	with a		1485 Cashtown R	d.					307				U.S.	-
	beath Pe 23	era	11. Marital Status	12. Was Deceder	nt Ever in U	.S. 13.	Was Deci	edent of Hi	ispanic Ori	igin? (Spe	ecify Yes or No Rican, etc.))-	14. Race - Am	erican Indian,
	72 hours after death with the Marylan "naturel", or Iteme 23e or 28e-f show tidical Examinar must be notified at	by Funeral	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Force 1 X Yes 2 [If Yes, Give Year or Dates	^{□ No} 64-		lf Yes, spe 1 □ Yes		n, Mexicar Specify:		Rican, etc.)		Black, Whi Specify:	te, etc. White
215-0036	hour fure		15. Decedent's Ed		•.	16a, Dece	dent's Us	ual Occupa	ation			16b. K	ind of Business	/Industry
Ċ	in 72	olet	(Specify only highest gra	de completed)		(Give	kind of w	ork done d use retired	durina mos	t of worki	ng			
_	within iene. r then	Completed	Elementary/Secondary (0-12)	College (1-4d	(f 5+)		Fa	rmer					Agricul	lture
	illed I Hygi other	0	17. Father's Name (First, Middle, Last)						18. Moth	er's Name	(First, Middle	, Maiden	Sumame)	
<u>a</u>	Aental Aental rked c	To B	Marcellus Weav	er						Mar	ie Walt	er		
Maryland	ss 1 end 2 should of Health and Men I Item 27 Ie marke r other treumatic		19a. Informant's Name/Relationship (Kimberly A. Weave				•				al Route Numb erville		r Town, State, 17307	Zip Code)
	s 1 end Health tem 27 other ti		20a. Method of Disposition		20b. F	 Place of Dispo cometery, crei	sition (Na	ime of	. ا ده		ate	20c. Lo	ocation · City or	Town, State
altimore,			1 ☐ Burial 2X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi			ithsbu				Nov.	006	S	mithsbu	ira.Md.
<u>=</u>	permit. Pag Depertment Importent: I eny injury o		21. Signature of Funeral Service Licer		,	22	2. Name a	nd Addres	ss of Facili				Bradbur	
ñ	Ded Person		Teller for I	Davis N	10/4/4	J.	L. D	avis	Fune	ral I	Home Sm	iths	burg, Mc	1.21783
	Physician // Medical Examiner policy of the prijar-Itausit policy of the p	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or and to compare to comp		uence of):	heal	<u> </u>	ail	OPE				Onset and Death
O. Box 68	ath certific	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 ☐ Feta at time of d	Ideath 3	□Ectopic □ Other (s	oregnancy specify)					23d. Date of de Month	olivery Day Year
<u>ر</u> م	res that the de signed by the e i be deteched t	by	Part II. Other significant conditions of	contributing to death	n but not res	sulting in the u	nderlying	cause giv	en in Part	I.		obacco u Yes 2		o the cause of death?
5	w require been si should I	ted				•								
Rec		Completed							·		24a. Was auto perfo		death?	utopsy findings available completion of cause of s 2 No
Ita	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?							e of Deatl	(Check only	one)		
<u>~</u>	hysic his ce I dire	ဥ	1 ☐ Yes 2 ☑ No	Hospital: 1 _ npa		ER/Outpatie	nt 3 🗆 🗆		4 🗀 🕅				6 □Other (Spe	ecify)
0	ng Pi		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of I	njury Day Year)	28b. Time o Injury		28c. Injun Work		1	28d. Describe	how inju	ry occurred	
Division of Vital Records,	I or Attending Physician: efter death. Director: After this certified I in by the funeral director, I	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place of	Injury - At h etc. (Speci	ome, farm, st fy)	M reet, facto		Yes 2		28f. Location (City or To	Street ar wn, State	nd Number or R	lural Route Number,
	To the Hospital or At within 24 hours effer of To the Funeret Direct completely filled in by	edlcal C		nysician: To the be minar: On the basis and manner	s of examina									
	To the Vithin Complex	Me	29b. Signature and title of certifier)			2	9c. Licens	e number			29d. Da	te signed (Mon	th, Day, Year)
)			1 Dey H.	00-1	MOTAL	Duie	(a,	IGST	THO	7.0		Jnv.	mate	20 2006
	€		30. Name and address of person who	completed cause of	of death (Ite	m 23a) (Type,		92 11				~ ~ ~	T17175 Pm	
_				PEENE	STR	ET	Ba	UTI	moR	F	MD	212	210	
	St: Regist	ate	31. Date filed (Month, Day, Year)	67	istrar's Sign	ature								

DHMH 17 Rev 1/2001

ORIGINAL

	í	For State Registrar	State of Maryla	nd / Depa <i>Cel</i>	artment of rtificate of	Health ar f <i>Death</i>	nd Mental Hy	/giene 006	38358
Physicia		Decedent's Name (First, Middle, Last, FRANCES LUCIL		J	***		2. Date of De Month NOV FMBF.	eath Day Year	3. Time of Death 9:00 P M
/Medica Examine		4a. Facility Name (If not institution, give TWIN OAKS ASSIST	street and number)	<u> </u>		or Location of t	Death	4c. County of Dea	
Funeral Director		5. Social Security Number 6. Se		. last birthday) Yrs.	If Under 1 Yea Months Day	r II Under 24		irth 9. Bi ay, Year) C	rthplace (State or Foreign ountry) GINIA
laryland •how	_	Usual Residence of Decedent 10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits
death with the Maryland ms 23a or 28a-f ehow rround be rediffed at	Directo	MD WASHIN	a I UN	MIL	LIAMSPOR			10g. Citizen of What C	1 ☐ Yes 2 No ountry?
Ind 21215-0036 be filed within 72 hours after death with the Maryla hall Hygiene. do other then "natural", or items 23a or 28a-f ehor event, the Modical Examinat must be notified at	Funeral Director	10808 ARCHER LANE 11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	217 Was Decedent of Il Yes, specify Cu	Hispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)	USA o- 14. Race - Am Black, Whi	
5-0036 72 hours aft natural', or	2	1 Never Married 2 Married XX Widowed 4 Divorced 15. Decedent's Edu	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No			Specify: WH	ITE Vadustov
ind 21215-0036 be filed within 72 hours after tal Hygiene. d other then "natural", or ite event, the Modical Examina	Completed	(Specify only highest grad		(Give	kind of work don DO NOT use retir	e durina most o	f working		HOME
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other then eny injury or other treumatic event, tra Ma	To Be C	17. Father's Name (First, Middle, Last) JOSEPH COOLEY					FANNIE GR		The same of the sa
Mary, Mary and 2 sho saith and 1 in 27 is me or troums		19a. Informant's Name/Relationship (Ty FRANCES SMALLWOOL			-			oer, City or Town, State, ORT, MD 217	
Baltimore, sermit. Pages 1a appartment of Her mportant: if tem ing fujury or other ince.		20a. Method ol Disposition 1 XX virial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Place of Dispo cemetery, crer ROSEDALE	sition (Name of natory or other pl CEMETERY		VEMBER , 2006	20c. Location - City of MARTINSB	
Balt permit. Depart import eny inj once.		21. Signature of Funeral Service Licens Challes TY	D. Blown				MAKIINS	321, 327 W. KI BBURG, WV 2540	NG ST.,
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Division of Vital Records, P.O. Box 68760, P. othe Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al déath 3 □	Ectopic pregnand Other (specify)	су		23d. Date of de Month	livery Day Year
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of Vital Records, hysician: The law requires the his certificate has been signed indirector, page 2 should be control.	ompleted						24a. Was auto perfo	psy prior to death?	utopsy lindings available completion of cause of
Vita	BeC	25. Was case relerred to medical examiner?	lospital:				Death (Check only	one)	
Division of located and locate	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju			idence 6 Other Spe how injury occurred	city) Living
Division Atternati	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, straify)	eet, lactory, office	•	28I. Location (City or To	Street and Number or R wn, State)	ural Route Number,
ne Hospit n 24 hour he Funera pletely fills	edicai	one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	ation and/or inv	estigation, in my	opinion, death of	occurred at the time,	date and place, and due	e to the cause(s)
To t withi To th	Σ	29b. Signature and title of certifier Cynthea Ku 30. Name and address of person who co Cynthia Kutther 31. Date filed (Month, Day, Year)	ttner son	d, no	29c. Licen	7451		29d. Date signed (Monitorial November 20,	th, Day, Year)
3		30. Name and address of person who co	Sands MD	m 23a) (Type,	Print) Sport No	H prist	me 1541	North Arti Maryland	zan Street 21795
Stat	е	31. Date filed (Month, Day, Year)	32 Registrar's Sign	atyre Go	whi				

Frances Lucille Williamson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 11 17 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Weshington 367 Kshire e/sou 05 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Frederick, MD Social Security Number 8. Date of Birth (Month, Day, Year) AUG 4 1955 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 218-64-3346 Director 51 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Hagerstown Washington 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 USA 363 Yorshire Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ☐ No Specify þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 12 Grants Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beverly Ann Haller Donald Thomas Ayers 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20121 Daniels Circle, Hagerstown, MD Keria Ann Gibson, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurist 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 Ø Other (Specify)
21. Sign state (Jude of Local Licens) Rest Haven Cemetery 11/21/06 Hagerstown, MD 22. Name and Address of Facility John T. Williams Funeral Home Barbara A. Williams, Owner 21716 100 Petersville Road, Brunswick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atheroscleretic Physician disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of and resulting in death) Last Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2□ No Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2.2 No certificate 1∐ Yes 25. Was case referred to medical examiner?
1 √ Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home Certification: To Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Natural Injury after death.

Director: A
d in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 within 24 hours a To the Funeral C

29b. Signature and title of certifier De056965 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown PO Carst Antiotom Kotoh 31. Date filed (Month, Da istrar's Signature 2006

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**E Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29a. Certifier

(Check only one)

Medical

State

Registrar

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Physician /Medica Examine **Funeral**

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any liqury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 **Physician**

/Medical **Examiner**

Registrar		Certific	cate of L	<i>Jeath</i>	F	Reg. No.	100	20266
1. Decedent's Name (First, Middle, Last)				2. Date of Dea		700	3. Time of Death
Regina D.	Woodfor	ck			Month //	Day 13	06	17:40 PM
a. Facility Name (If not institution, give	street and number)	4b.	City, Town, or	Location of Death	1	4c. Count	y of Death	
Peninsula Region	al Medical Ca	enter 10	DEC	arroll Si	/	Salist	ALOMI	MD 21201
. Social Security Number 6. Se	7. Age (In yrs.	last birthday) If U	Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	2		ace (State or Foreign
none	□ M 2 🕱 F 101	Yrs.	Days		12/25	/1904		siana
Usual Residence of Decedent Oa. State 10b. County	10c Ci	ty, Town or Location	2				10	d. Inside City Limits
								1 [¾ Yes 2 □ No
aryland Wicomico) 50	alisbury				10 02	1411	
Oe. Street and Number 1412 Ard Brac Pla	ace		of. Zip Code 218			10g. Citizen of USA		
1. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was I	Decedent of Hi	spanic Origin? (Sp n, Mex i can, Puert	pecify Yes or No- o Rican, etc.)	14. Ra Bla	ce - America	
1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 X No If Yes, Give		es 2X No	Specify:			tv: Afr	ican/Ameri
3 X Widowed 4 ☐ Divorced	Year or Dates:					1		
15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Decedent's	Usual Occupa of work done of	ation luring most of wor)	king	16b. Kind of E	Business/Ind	ustry
Elementary/Secondary (0-12)	College (1-4or 5+)			,		Domo	stic	
/		Homema	ver	18. Mother's Nam	no (Firet Middle			
7. Father's Name (First, Middle, Last)	S				Barthe.		ine)	
Prosper Duplessis		1					-	
9a. Informant's Name/Relationship (T				and Number or Ru				Code)
Ursula Lyons/daugl				Place,				
Da. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Bemoval from State Day	Place of Disposition cemetery, cremator	n (Name of ry or other plac	e)	Date	20c. Location	•	
4 □ Donation 5 □ Other (Specify)_ PE	cemetery, cremator covidence cemetery	Mellori	ar 11/	28/06	New O	rleans	s, LA
1. Signature of Funeral Service Lice					Home Pro	fession ury, MI	al As 2180	sociation 4
23a. Part1. Enter the disease, or comp	olications that caused the dea							Approximate Interval Between
shock, or heart failure. List only of mmediate Cause (Final	.) -1	1	E				1 2	Onset and Death
disease or condition resulting in death)	a. Due to (or as a con	olvatury	Fail	VIC			-	3 days
	Due to (or as a conser	querice oi).						
Sequentially list conditions,	b. Due to (or as a conse	quence of):						
Sequentially list conditions, if any, leading to immediate cace. Enter underlying Cause (Disease or injury								
that initiated events resulting in death) Last	Due to (or as a conse	quence of):						
	.d							
F FEMALE:	23c. If yes, outcome pf pregr	nancy				224 0	ate of delive	n/
23b. was decedent pregnant	1 Live birth 2 ☐ Fet	tal death 3 ☐ Ecto	opic pregnancy ner (specify)			1		ry Day Year
in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	ueatti 5∐Oth	iei (specily)					
Part II. Other significant conditions of	ontributing to death but not re	sulting in the under	vina cause div	en in Part I.	23e. Did to	obacco use co	ntribute to th	e cause of death?
			,g 50056 giv					ably 4 ⊠Únknown
Peripheral VA	JUINV DI OUT	, ~				. 55 2 140	0 L 100	and The Christian
					24a. Was autor	osy	prior to cor	psy findings available npletion of cause of
					perfo	rmed? 2 No	death?	2 □ No
25. Was case referred to medical				26. Place of Dea	ath (Check only o			
examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Oth	er: 4 Nursing H	lome 5 ☐ Resi	dence 6 □O	ther (Specif	()
7. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how injury occu	ırred	
1 Natural 5 Pending 2 Accident investigation				Yes 2 □ No				
3 Suicide 6 Could not be	Zoe. Flace of Injury - At I		factory, office		28f. Location (Street and Nun	nber or Rura	l Route Number,
4 Homicide determined	building, etc. (Spec	шу)			City or To	vii, Statej		
29a. Certifier 1 Certifying Ph	nysician: To the best of my kr	nowledge, death occ	curred at the ti	me, date and place	e, and due to the	cause(s) and r	nanner as s	tated.
(Check only 2 Medical Exam	miner: On the basis of examir and manner stated.	nation and/or invest	igation, in my	pinion, death occ	urred at the time,	date and place	e, and due to	the cause(s)
29b. Signature and title of pertifier			29c. Licens	e number		29d. Date sign	ned (Month,	Day, Year)
A House	, ,,,,		D//	1012		11-10	1-06	
Jame Julia	u mo		1 24	1813		4 /	<i>(a)</i>	

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Tregina Wood fork 900-30-2967 Division or Vital Records, P.O. Box 68760,

> State Registrar

30. Name and address reson who completed cause of death (Item 23a) (Type, Print)

J. Steve Julian, Mi) 201 Rine Bli 31. Date filed (Month, Day, Year) NOV 1 6 2006

32. Registrar's Signature

Suite 25

21801

6-08930		Please Type or Print in Black Indelible Ink
heodore Water	s, J	Code of Manyland / Department of Fledigitation Montain Tygionic
Physici	n/	Reg. No. C. UUU 3030
Medical Exami		Month Day Year
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Funeral		McCready Memorial Hospital Crisfield Somerset 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director		220-13-84-75 174M 2 F 31 Yrs. Months Days Hours Min. 09 - 24 - 75 Foreign Country) Md
		Usual Residence of Decedent
w any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit 10a. State 10b. County 10c. City, Town or Location 1 1 Yes 2 MN
Maryland 28a-f show d at once.	ctor	Md. Somer Set Upper Hr // 10e. Street and Number 10g. Citizen of What Country?
ith the Maryland 23a or 28a-f sho notified at once	Director	27830 Jim Moore Rd. 21867 U.S.A.
with th ms 23a be notil		11. Marifal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
er deatl	Funeral	1 Yes 2 No
urs aftı tural" amine	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
136 Ithin 72 hours a te. Ethan "natural	lete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)
5-0036 iled within 72 Hygiene. I other than 'the Medical	Completed	12 Production Worker Tendue tarms 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 4 Nes Handy
2121 hould be find Mental Jis marked	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
a in alt of		Agres Waters (mother) 21830 Jim Moore Rd Upper Hill, Md 21867 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 160c. Location - City or Town, State
iore ges la it of He :: If ite		1 XBurial 2 Cremation 3 Removal from State crematory or other place)
e a B B B B		4 Donation 5 Other Specify: 1-AMY Mem. Cem. 12/2/06 VPOP HIII, Md. 21. Signature of Fineral Service Licensee J 22. Name and Address of Facility
Balt permit Depart Impor		Bernie Smith F/H SAUSBURY, MD 21801
Physician /Medical		23a. Part I. Exted the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease a. Acute alcohol intoxication Death or condition resulting in death) Due to (or as a consequence of):
	L	Sequentially list conditions, b.
	miner	if any, leading to immediate Due to (or as a consequence of):
ed sit	Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
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687 certific nding 1 se as t	ian/	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (Specify) Month Day Year
Box 68760, re death certificate be the attending physic red for use as the burned for us	Physician/Medi	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown
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Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	T:uc	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
isior Attenc r death ector: by the	catio	2 Accident Pending Investigation Find 11/23/2006 Find 6:27 pm Tes 2 X No unknown
Division ospital or Attenchours after death meral Director:	Certification:	Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2/830 Jimmoora Road Westover. MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 24, 2006
		30. Name and eddress of person who completed cause of death (Item 23a)
		Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	ate	
Regist	чец	NOV 2 9 2006 Blacus & Sparter

			1 - For State Registrar	State of Ma		epartmer Certificat					Reg. No.	006		3836	2
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	/Medio		4a. Facility Name (If not institution, give		vocicy		Town, or	Location of	Death	Nov	4c.	County of D		1730	T IVI
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	Funeral		Social Security Number 6. S	ex 7. Age	e (In yrs. last birth	Months	Days	If Under 24		B. Date of Birt (Month, Day	h y, Year)	9.	Birthpla	ace (State or Fo	oreign
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	ow ow		10a. State 10b. County		10c. City, Town	or Location							10	d. Inside City L	imits
	Man	tor	Maryland Howard		Dayton									1 ☐ Yes 2	No 2
	or 28	Director	10e. Street and Number			10f. Zip	Code				10g. Citi:	zen of What	Count	ry?	
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	item item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent 8 Armed Forces?		13. Was Dece If Yes, spe	dent of His cify Cubar	panic Origi , Mexican,	in? (Speci Puerto Ri	ify Yes or No- ican, etc.)	. '	I4. Race - A Black, W			
936	urs aft	by	3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	1942-	1 ☐ Yes	2 No №	Specify:				Specify:	Wh	ite	
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and	Mental I	To Be	Leon Aldred Welch					Esthe		i ii si, iviiddio,	Walder	Surriaine)	D	olston	
Maryland	S E E	۲	19a. Informant's Name/Relationship (19b. N	Mailing Address	S (Street a			Route Numbe	r, City or	Town, Stat			
			Shirley Mulkern	(Daughte		Bryn Ma	wr C	t. Fal	Hing	Water	s. N	V 254	19		
ore	ges 1 an it of Heat if item 2 or other		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Cometery,	Disposition (National Communication of C	me of other place)	Dat			cation - City		vn, State	
Ë	. Pages tment of tant: If it jury or o		4 Donation 5 Other (Specific	y) <u>,</u>	Cresti	awn Mem	. Par	-k [11	1-24-	2006 R	iver	side,	Ca	liforni	а
Baltimore,	permit. Pag Department Important: I any injury o		21. Signatury Foreral Service Light			22. Name ar Osborn St. Wi	e Fur Ilian	of Facility neral nsport	Home t, Ma	P.A.	425 21	S. Co 795	noc	ocheagu	е
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of	Phys this rat dii	. To	1 ☐ Yes 2 No 27. Manner of Death	1 L Inpatie				4 114015		d. Describe h			pecify)		
O	Attending in death.	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year) Inji	Jry M	28c. Injury Work′ 1 ⊟ Y	es 2 □ No	i	d. 2030/100 //	OW IIIIQIY	occurred			
Division	ii or Attend after death Director: A d in by the f	Certification:	3 Suicide 6 Could not be determined		ury - At home, larm	n, street, lactor	y, office		281	I. Location (S City or Tow	treet and	l Number or	Rural	Route Number,	
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24	1-10+1		30. Name and address of person who	completed cause of de	eath (Item 23a) (T	ype, Print)	/	1	1	bra 1	1	7/2/1/	11		
W. H.	Sta	te	31. Date liled (Month, Day, Year)		ar's Signature	xca	Carl	i (1)	wil	via 1	11)	alug	4_		
	Registr		NOV 202	006	and B.	Soules									

State of Maryland / Department of Health and Mental Hygiene 006 38363 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Chetister Long Anderson, Jr. November 25,2006 8:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Montgomery Rockville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Days Hours 1⊠M 2□F Director 228-09-2481 90 May 13, 1913 Virginia Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f ehow the Madical Examiner must be notitled at 1X Yes 2 □ No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8505 Springville Road 20190 USA filed within 72 hours after death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∑Yes 2 □ No 1941— If Yes, Give Year or Dates: 1945 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No African Specify: þ 3 ☐ Widowed 4 ☑ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Auto Mechanic 12 Auto Dealership permit. Pages 1 and 2 should be tile Department of Health and Mental Hy Important: If Item 27 is marked ofth eny injury or other traumatic event, song: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Chetister Long Anderson, Sr. Carah Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretta L. Granderson/Daughter 3300 Greencastle Rd., Burtonsville, MD 20866 20b. Place of Disposition (Name of cemetery, crematory or other place)
Trough Hill Primitive
Baptist Church Ceme 11-30-06 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Hume, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joynes Funeral Home, Inc. PO Box 3633, Warrenton, VA Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or/heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOMYOPATHY **Physician** SCHEMIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner nding physicien and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical attending for use as 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 20 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After the 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 4 2006 Registrar

			For State Registrar	State of Ma		artment of I rtificate of	Health and Me Death	ental Hygien Reg. N	2000	38364
	Physici		1. Decedent's Name (First, Middle Marianna Bret)	,				Date of Death Month D Vovembe	ay 28 Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution Memorial		at Easton	4b. City, Town,	or Location of Death		c. County of Death	
	Funeral Director		5. Social Security Number 579-40-8723 Usual Residence of Decedent	6. Sex 7. Ag	e (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Year an 27, 19		place (State or Foreign ntry) Virginia
)	Maryland -f show	tor	10a. State 10b. County MD Caroli	ne	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	Direc	10e. Street and Number 4105 Frazier Ne	ck Road		10f. Zip Code	21655	10g. C	itizen of What Cou	ntry?
36	s 1 and 2 should be filed within 72 hours after deeth with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, its Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Marr 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? ied 1 Yes 2 X	10	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🖁 No	Hispanic Origin? (Speci pan, Mexican, Puerto Ric	fy Yes or No- can, etc.)	USA 14. Race - Ameri Black, White Specify: W	
21215-0036	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "naturel"; 'aumatic event, the Mudical Exa	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education	(Give	DO NOT use retire	during most of working ad)		Kind of Business/Ir	,
	Hygie Hygie other t	e Co	12 17. Father's Name (First, Middle,	Last)		office	manager 18. Mother's Name (I			ental Serv
ylan ylan	Mental Mental Brked c	To Be	Ray Lewis Bart	lett			Lenore	Strickle	r	
Maryland	d 2 sho th and 7 is ma trauma	0 9	19a. Informant's Name/Relations Timothy Breth/s		1		t and Number or Rural F			
Baltimore, I	permit. Pages 1 and 3 Department of Health Important: if Item 27 any Injury or other tra		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 ☑ Donation 5 □ Other (6)	3 ☐Removal from State	20b. Place of Dispo		Neck Road		MD 2165 Location - City or T	
Balti	permit. Departn Imports any Inju		21. Signature of Funeral Service Ronal d	wade ire	_		ess of Facility Comy Board 6 MD 21201	555 W. Ba	ltimore S	treet
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	the death. Do not ent ne.	er the mode of dyi	ing, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death ImonH
8760,	cate be executed bhysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of): a consequence of): a consequence of):	splast	tic Syro	home		24ears
P.O. Box 68	The law requires that the death certificates has been signed by the attending pipage 2 should be detached for use as in	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1	2 Fetal death 3	Ectopic pregnanc Other (specify)	·y		23d. Date of deliv Month	ery Day Year
	w requires that I been signed by should be deta	۵	Part II. Other significant condition	vns contributing to death be	ut not resulting in the u	nderlying cause giv	ven in Part I.		V.	he cause of death?
Il Records,		Completed						24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	prior to co death?	psy findings available mpletion of cause of
of Vital	Physician: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatie	- 4 C FD/O		26. Place of Death (C	11000000		
Division of	To the Hospital or Attending Physical within 24 hours elied death. To the Funeral Director: Aller this completely filled in by the funeral di	Certification; To	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date of Injury (Month, Day ation	y 28b. Time of	28c. Injui	4 Indising Home	5 ☐ Residence 1. Describe how inju		ý)
Divi	tal or Att rs efter d al Direct ed in by t	Certific	3 Suicide 6 Could r 4 Homicide determ	28e. Place of Inju	ury - At home, farm, str. c. (Specify)	eet, factory, office	28f	Location (Street a. City or Town, Stat	nd Number or Rura e)	l Route Number,
	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the fune.	Medical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the best of Examiner: On the basis of and manner sta	examination and/or inv	occurred at the tile restigation, in my o	me, date and place, and opinion, death occurred	due to the cause(s at the time, date an	and manner as s d place, and due to	tated. o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1 ,1100	. > 1	29c. Licens		29d. Da	ate signed (Month,	,
			30. Name and address of per on	o completed cause of de	eath (Item 23a) (Type,	Print)	47232	(1	28/20	06
			Mary Spencer 31. Date filed (Month, Day, Year)		Easton,	Md. 2160	1			
	Sta Registr		DEC 0_4	A.C.	a a signature	and a				

			1 - For State Registrar	State of Ma	ryland / Depa		Health and	Mental Hy	7 11111	5 38365
			1. Decedent's Name (First, Middle, La	net)	Cei	runcate of	Death	2. Date of De	Reg. No.	
	Physici	an			0.11			Month	Day Y	3. Time of Death
	/Media			gnes	Butle		and anning of Dank		27. 2006	11:15 M
	Examir	ier	4a. Facility Name (If not institution, gi	e street and number)		BALTIM	or Location of Deat	1	4c. County of	Death
			SINAL HOSPITAL 5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday)	If Under 1 Yea		8 Date of Bir		1
	Funeral Director		,	4 T 14 0 Set F	Yrs.	Months Day:		8. Date of Bir (Month, Da	ay, Year)	Birthplace (State or Foreign Country) SC
			Usual Residence of Decedent		<i>'</i>			00. N	. 1920	- 30
	yłanc w or		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mar.	ţo	MD NA		BALTIMOR	E				1 ⊠ .Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	th wi	a	3713 SPRINGDALE	AVENUE		212	lle		USA	F
	de F	Ine	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race -	American Indian, White, etc.
36	or H	УFL	1 Never Married 2 Married	1 ☐ Yes 2 🔯 N If Yes, Give	0	1 ☐ Yes 2 🗹 No		,	1	·
ë	72 hours after death with the Maryland natural', or iteme 23a or 28e-f ehow iteal Examinar must be notified at	d by	3 Widowed 4 □ Divorced	Year or Dates:	140.0				Specify:	suack
5	n 72	lete	15. Decedent's E (Specify only highest gi	ade completed)	(Give	dent's Usual Occi kind of work don DO NOT use retir	e during most of wor	king	16b. Kind of Busin	ness/Industry
21215-0036	4 within 72 hours after death with the Marylan liene. r then "natural", or iteme 23a or 28e-f ehow the Madical Examiner man be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	MSTRESS	*		CLOTHIN	G
0	Hyg Hyg ent.		17. Father's Name (First, Middle, Las			11-11-0		ne (First, Middle	, Maiden Sumame)	9
<u>a</u>	ld be ental ked c	To Be	EDEN SCOTT				EUGENI	4 JONE	8	
Maryland	d 2 shou th and M 7 is mar treumati	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Stree			er, City or Town, Sta	ite, Zip Code)
	alth a		SYLVIA BUTLER (1	DAUGHTER)	3113	SPRINGE	ALE AVE	BALTO), mp 2	12110
ē,	s 1 and if Heali item 2 other		20a. Method of Disposition		20b. Place of Dispo		1	Date	20c. Location - Cit	y or Town, State
Baltimore,	Pages ment of I ant: If ito ury or o		1 ■ Burial 2 □ Cremation 3 (4 □ Donation 5 □ Other (Spec		WOODLAW		1	2.06	BALTIMOR	RE , MD
a E	# # # # #		21. Signature of Funeral Service Lice	ns ee -	22	. Name and Add	ress of Facility GREENE F	244604	250,405	3 1110
m	Deperiment impo		Vaucher C	4	51	51 BAUM.	MATE PIK	E BAIR	o. MD 212	29
			23a. Part1. Enter the disease, or con shock, or keart failure. List only	plications that caused one cause on each lin						Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a	consequence of):	(110				
	Examiner		Sequentially list conditions.	b	B	nem	19			
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):		61			
	and and Il-tran	xan	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):	1280	itticle	ney		
760,	ate be executed hysicien and the burial-transit	calE	l l	Ar	Lenal consequence of):	100	ma Co.	A nivo	ceuler 1	15050
	ficate physis the			d	, 0 (0)	rero	110		, C. C. C.	
Вох	death certifical e ettending phy id for use as th	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date o	f delivery
m.	death e ette d for	cla	in the past 12 months? 1 ☐ Yes 2 ☑No	1 ☐ Live birth : 4 ☐ Pregnant at		Ectopic pregnant Other (specify)	cy		Month	Day Year
о. О.	s thet the de ned by the e detached t	Physician/Med	9 ☐ Unknown	9□ Unknown						
	law requires thet the as been signed by th 2 should be detache	by P	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause g	iven in Part I.	23e. Did t	obacco use contribu	te to the cause of death?
ğ	w requir been si should							1 🗆 '	Yes 2 % 2No 3[☐ Probably 4 ☐ Unknown
ec	e law r has be je 2 sh	Completed						24a. Was		re autopsy findings available r to completion of cause of
<u> </u>	The ete	Son						perfo	ormed? deat	
/ita	Physician: 'this certifice ral director, p	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o		
\leq	S ≅ ₽	ဥ	1 ☐ Yes 2100No	Hospital: 1 Inpatier	nt 2 ER/Outpatier	t 3 DOA	ther: 4 Nursing H	ome 5 ☐ Resi	dence 6 Other (Specify)
ב	ing P	ë.	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time of Injury	W	ork?	28d. Describe I	how injury occurred	
sio	Attending r death. sctor: After by the funer	catl	2 Accident investigation 3 Suicide 6 Could not t				Yes 2 No			
=	or At	Certification:	4 Homicide determined		ry - At ho <i>m</i> e, farm, str . <i>(Specify)</i>	eet, factory, office	•	28f. Location (3 City or Tox	Street and Number o wn, State)	or Rural Route Number,
	spitel		29a. Certifier 1 📈 Certifying P	hysician: To the best o	f my knowledge death	a acquired at the	time date and place	and due to the	2010-1010-1	
	To the Hospitel or Attending Phenships within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	edical	(Check only 2 Medical Exa	miner: On the basis of and manner star	examination and/or in	estigation, in my	opinion, death occu	rred at the time,	date and place, and	or as stated. due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date signed (A	-
			- The			DE	30115		11/30	16
1	1		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print)		11 - 1		
)			ino =	2311 019	H Rd	Randa	IIStow	n mp	21133
	Sta Registr		31. Date filed (Month, Day, Year) DFC 0 4 200	6 Hegistra	r's Signature	E)				

2006

Black, White, etc

Month

Grosvenor Dr. Ellicott City, MD 21042

Year

Day

hmore

Birthplace (State or Foreight Country)

Pennsylvania

10d. Inside City Limits

1 Yes 2 No

01 State

DHMH 17 Rev 1/2001

Registrar

Nicholas

31. Date filed (Month, Day,

Medical Reside

3602

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 ed ford

Year)

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 20 2006 JIMMY **BROADY** 12:33P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11102 LAKE VICTORIA LANE BOWIE PRINCE GEORGE'S | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | MARCH | 12 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral 1** M 2□F 1943 TENN. Director 413-70-0673 63 Yrs. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examinar moust be notified at MD PRINCE GEORGE'S BOWTE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 11102 LAKE VICTORIA LANE 20720 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ★Yes 2 □ No NAVY
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "naturel", or Iter Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICAL ENGINEER GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JESSIE MALONE 2 LAURA **BROADY** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr eny injury or other traum once. BARBARA BROADY/WIFE 11102 LAKE VICTORIA LANE BOWIE, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ★Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON CEMETERY 12/21/2006 ARLINGTON, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease shock, or heart failurg. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC COLON CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has performe 1 🗆 Yes 2 No 2X No 1 Yes the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number OH 35- 073311 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

GUCHUAN D.

31. Date filed (Month, Day, Year)

ZHU M.D.

0 4

32. Signature

8901 WISCONSIN AVENUE BETHESDA, MARYLAND 20889

		1- For State Control of Land C			No. 2006	38368
Physici Medical Exam	an/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month November	Day Year	3. Time of Death 0103 hrs
neulcai Exaili	illei	William Harry Beebe Jr. 4a Facility Name (if not institution, give street and number) 4b.	City, Town, or Location of Death	November	28, 2006 4c. County of Death	——————————————————————————————————————
			Bel Air		Harford	
Funeral			If Under 1 Year If Under 24Hrs	8 Date of Birth	(MM/DD/YYYY) 9. Birt	
Director		217-21-1562 1 × M 2 F 28 Yrs.	Months Days Hours Min.	Feb. 6	, 1978 Foreign	n ^{intry)} Maryland
ý.		Usual Residence of Decedent 10a. State 10b County 10c City, Town or Location				10d. Inside City Limits
id how a	L	Maryland Harford Abingdon				1 Yes 2 X No
Maryland 28a-f show any d at once.	Director		Of, Zip Code	100	g. Citizen of What Coun	try?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once		130 Long Meadow Ct.	21009	τ	JSA	E'
th with ems 2: t be m	eral		Decedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto R		14. Race - Americ White, etc.	an Indian, Black,
er dear , or it r mus	Fun	1 Yes 2 X No	es 2X No specify	,		hite
urs aft tnral" amine	d by	or Dates:	Usual Occupation (Give kind of wo	ork done	Specify W 16b Kind of Business/Ir	
5 72 ho in "na	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use retire	d)	Harford Co	unty
DO3(within iene. rer tha	Complete	1 Deputy			Government	
15-(filed il il Hyg ed oth t, the	a)	17 Father's Name (First, Middle, Last) William Harry Beebe Sr.	18. Mother's Name (I		ŕ	
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Division tal or Attendir rs after death at Director: A	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, f	actory, office building, etc. 2	8f. Location (Str	eet and Number or Rura	al Route Number, City
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Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred (Check only of the basis of examination and/or investigation				
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	2	296 Signature and title of dertifier	29c License number O.C.M.E.		29d. Date signed <i>(Mont</i> November 28, 200	
7	(39 Name and address of person who completed cause of death (Item 23a)				
15	1	, , , , , , , , , , , , , , , , , , , ,	treet, Baltimore, MD 21201	1		
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SO SO TO SO		the at	sicl	1 ☐ Yes 2 🗷 No		at time of dea								Month	L	Jay	Year
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06-08949 Jennifer Bower

		1- For State Registrar		- Iviai yiai ia		ificate			Wentari		eg. No.	006	38371
Physicia	"	1 Decedent's Name (First, Midd	lle,Last)							Date of Dea Month		Year	3. Time of Death
Medical Examin		Jennifer Bower								1	r 24, 2006		0901 hrs
- way		4a Facility Name (if not institution	on, give s	treet and number)			,		ocation of Deat	h	4c. Coun	ty of Death	
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Funeral Director		5. Social Security Number	6. Sex	/. Ag		st birthday)	Mont	ths Days	If Under 24Hr Hours Mil	_	tn(MM/DD/YY	Foreign	nplace (State or
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene int. If item 27 is marked other than "natural", or items 23a or 28a-fshor other traumatic event, the Medical Examiner must be notified at once	uneral Director	11. Marital Status 1 X Never Married 2 M		2. Was Decedent Armed Forces?					anic Origin? (S Mexican, Puerti	pecify Yes or No Rican, etc.)		ace - Americ hite, etc.	an Indian, Black,
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Baltimore, permit. Pages I at Department of Hes Important: If ite injury or other tr	1	21. Signature of Funeral Service	License		MO1/.7		Name and	A Address of Pump	f Facility hrey Fun	eral Home,	Rockvil	le, In	c., 300 West
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876 tificat ng ph	틝	23b. Was decedent pregnant in t	he	1 Live birth	ie or pregni		Fetal death	3	Ectopic pregn	ancy	Month	-	ay Year
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Division pital or Attencours after death eral Director:	<u>[</u>	• -	stigation	28e. Place of Inj	ury - At hor	ne, farm, st	reet, factor	y, office buil	Iding, etc.	stopped at r 28f. Location (\$		nber or Rura	al Route Number, City
Div	틼	dete	Id not be ermined	(Specify) Ma	or Road	/ Highwa	av			or Town, S Route 175 at	tate)		
hou hou		29a Certifier	hysician	: To the best of my				ie time idate	and place and			-	
To the Ho Within 24 F To the Fu	ig	Check bing	miner:0	n the basis of exar									
To To Com	Medical	29b. Signature and title of certific		nd manner stated			29	Oc. License r	number		29d. Date se	gned (Mont	h, Day, Year)
		70.1	P	A				O.C.M.	.E.		Novembe		
	1	20 Name and address of the	2	anleted assists at) noth /lt 1	23.0\						,	
10	ļ	30 Name and address of persor Zabiullah Ali, M.D.		npleted cause of d ant Medical Ex		,	enn Stre	et, Baltim	nore, MD 21	1201			
Sta	ate	31. Date filed (Month, Day, Year)		32 Registra			AP a						
Registr		DEC 0 4	2006	Bloker	o De	ROM	Mer.						

06-08863 Margaret Bravo

gaa. z.a		1- For State Registrar	•	ate of Death	id Mental n	, ,	g. No. 2006	3837
Physici Medical Exami		1. Decedent's Name (First, Middle,Last) Margaret B	ravo			Date of Death Month November	Day Year 20 2006	3. Time of Death 2300 hrs
		4a. Facility Name (if not institution, give street and number) Sinai Hospital		4b. City, Town, o	r Location of Death		4c. County of Death	1
Funeral			e (In yrs. last bir		ar If Under 24Hrs	s. 8. Date of Birth	n(MM/DD/YYYY) 9. Birt	
Director	Ì	1 M 2 K F	51	Yrs. Months Da	ys Hours Mir	Apr.2	5,1955 Foreig	n untry) Virgini
' any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location	•	-		10d. Inside City Limits
Maryland 28a-f show any d at once.	tor	Md n/a	Bal:	timore		Liõ	0.10	1 XYes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once	I Director	4507 Bonner Road		10f. Zip Code 212			g. Citizen of What Cour	itry?
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 3 Widowed 4 Divorced If Yes, Give Year		13. Was Decedent of H If Yes, specify Cuba	in, Mexican, Puerto		White, etc.	can Indian, Black,
ours aft atural" samine	d by	15. Decedent's Education (Specify only highest grade com	pleted) 16a.	1 Yes 2 N	ation (Give kind of		Specify: D 16b. Kind of Business/I	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hou ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "nat or other traumatic event, the Medical Esa	Completed	Elementary/Secondary (0-12) College (1-4 or $\{11th\}$	5+)	during most of working lift Nurses Aid		ired)	Private	Care
21215-0036 wild be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Last) Robert Worsham				e (First, Middle, Ma	,	
ore, MD 2121 es I and 2 should be f of Health and Mental If item 27 is marker her traumatic event,		19a. Informant's Name/Relationship (Type, Print)		b. Mailing Address (Stre				
, MD and 2 sho ealth and tem 27 is	-300	Joyce C. Worsham (siste	20b. Place	936 Cornwa	11 Road	Baltir Date	nore, Md	21222 Town, State
Baltimore, permit. Pages I an Department of Hea Important: If ite		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify.	. I cremat	iew Cremat	ory 11-	29-06	Baltimore	,Maryland
		21 Signature of Funeral Service Licensee Tobust Marketine A.		22. Name and Address 1201 Dun	^{ss of Facility} Kac dalk Av	zorowsł e. Balt	ci Funera imore, M	1 Home,PA d, 21222
Physician /Medical		23a. Part I. Enter the disease, or complication that caused failure. List only one cause on each line.		ot enter the mode of dying	i, such as cardiac d	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Alcohol and Due to (or as a conse		IIILOXICALIOII				
***	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	quence of):					-
70	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a conse	quence of):					
760, icate be executed physician and the burial - transit		d						
760, reate be executed physician and the burial - transi	Medical	X UNPENDED #23 IF FEMALE: 23c. If yes, outcome the second		perME, g862, 1	12/12/06 TI	1	23d. Date of delivery	
Box 687, e death certificathe attending ped for use as th	sician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Pregnant at		Fetal death 3 Other (Specify)	Ectopic pregna	ancy		ay Year
D. Boy trhe death by the att	Phys	1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death	but not resultin		given in Part I	23e Did tob	acco use contribute to t	the cause of death?
F. P.O. ires that the signed by	ð						2 No 3 Prob	
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certification of the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed					24a. Was ar autopsy perform	y prior to ci	topsy findings available ompletion of cause of
tal Rection: The certificate ector, page	e Cor	25. Was case referred to medical		26.Plac	e of Death (Check	1 Yes 2	No 1 ✓ Ye	s 2 No
Vita hysicia rthis ce	To B	TV Tes 2 NO	nt 2 🗸 ER/O				esidence 6 Other:	
on of nding Pl th r: After re funera		27. Manner of Death 1 Natural 5 Pending 28a. Date of Inju (Month, Day, Yr	ear)		ury at Work? Yes 2 💢 No	28d. Describe ha unknown	w injury occurred	
Division of Vital Rec pital or Attending Physician: The I ours after death eral Director: After this certificate I filled in by the funeral director, page	ertification	3 Suicide 6 X Could not be 28e. Place of In	ury - At home, fa	arm, street, factory, office	-	28f. Location (Str or Town, Sta	reet and Number or Rur ate) 2401 W. Be	al Route Number, City 1 vedere Avenue
To the Hospital within 24 hours: To the Funeral completely filled	O	4 Homicide 29a Certifier (Check only 1 Certifying Physician: To the best of my		ath occurred at the time, o	late and place, and	due to the cause	MD (s) and manner as starte	ed.
To the Howithin 24 h To the Fur	Medical	one) 2 Medical Examiner:On the basis of examiner and manner stated. 29b. Signature and title of certifier	nination and/or i	nvestigation, in my opinio				
		Theodor Il Kill	2		M.E.		29d. Date signed <i>(Mon</i> November 21, 20	
		30. Name and address of person who complete cause of d	,	ines 444 D : 01	brook Dell'	- MD 04001		
9	ate	Theodore M. King, Jr., MD. Assistant M 31. Date filed (Month, Day, Year) 32. Restran	edical Exam		treet, Baltimor	е, MD 21201		
Regis	_	DEC 0.4 2006	we ser	F				:

06-08780 Siegfried Crothers

ologinou oromo		1- For State Control of Pleating and Weight in Certificate of Death	, ,	g. No. 2006	38372
Physicia Medical Examin		1. Decedent's Name (First, Middle,Last) Siegfried Crothers	2. Date of Death Month November		3. Time of Death 0751 hrs
/ X	101	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		18, 2006 4c. County of Death	
		1300 Chesapeake Avenue Baltimore City			
Funeral Director		5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	1.	Foreig	
Bircotor		Usual Residence of Decedent	Aug 3,	1946 Co	untry)
/ any	ı	10a State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show any d at once.	ğ	MD Baltimore			1 X Yes 2 No
the Mary 3a or 28a	Director	10e. Street and Number 1300 Chesapeake Avenue 10f. Zip Code 21225	10	g. Citizen of What Cour	^{ntry?} unk
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Married 12. Was Decedent Ever in U.S., Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Signer) (Sig		14. Race - Ameri White, etc.	can Indian, Black,
rs after ural",	ē,	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of Vice in the Complete of Vice in the	work done 1 I	Specify: whit	
2 hour	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	ired)	16b. Kind of Business/I	ndustry unk
O36	Completed	unk unk	2.01		
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be Co	17. Father's Name (First, Middle, Last) unk 18. Mother's Name	e (First, Middle, M	aiden Surname)	unk
e, MD 2121 I and 2 should be fi Health and Mental litem 27 is marker traumatic event,	리	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I			Zip Code)
e, MD I and 2 sho Health and item 27 is	F	O.C.M.E. 111 Penn Street Balt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		MD 21201 20c. Location - City or	Town State
		1 Burial 2 Cremation 3 Removal from State crematory or other place)	Julio	250. 250dilon Oky di	Town, oldie
Baltimore permit. Pages Department of F Important: If injury or other	+	4 Donation 5 X Other Specify in state 21. Signal re of Euneral Service Licensee 22. Name and Address of Facility State Anatomy Board	1	nil-2	
		Baltimore, MD 2120)		Street
Physician /Medical		23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate ause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			Death
		Sequentially list conditions, b			
	in e	if any, leading to immediate Table Enter Underphit Cause (Disease or injury that initiated			
red	Examiner	events resulting in death) Last Due to (or as a consequence of):			
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED			
760, icate be physical the buri		IF FEMALE: 23c. If yes, outcome of pregnancy		23d Date of delivery	
Box 687 e death certifi the attending ed for use as t	sician	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	ancy	Month D	ay Year
BO)	Physi	1 Yes 2 No 9 Unknown 9 Unknown			
Division of Vital Records, P.O. ral or Attending Physician: The law requires that th rs after death. **In Director** After this certificate has been signed by led in by the funeral director, page 2 should be deach.	ğ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to t	
ords, w requires s been sig	Completed		24a. Was ar		opsy findings available
e law re has t	du		autopsy	ned? death?	ompletion of cause of
tal Rec	Be Co	25. Was case referred to medical 26.Place of Death (Check	1 Yes 2 only one)	No 1 Ye	s 2 No
Vit;	P P	1 100 Z 110	ng Home 5 R	tesidence 6 🗸 Other:	Scene
ision of Attending Pher death.		27. Manner of Death 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe ho	ow injury occurred	
'iSiO - Atten er deat rector	icati	2 Accident Investigation 28e Place of Injury. At home form street factory office huilding the	28f. Location (Str	reet and Number or Rur	al Route Number City
Divisior beginal or Attend hours after death meral Director;	Certification:	Suicide 6 Could not be determined (Specify)	or Town, Sta		,
Division of Vital Records, P.O. Box 68: within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an			
To COI	We	and manner stated 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mon	th, Day, Year)
		(arde Hallam O.C.M.E.		November 18, 20	06
	Ī	30 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	1		
St	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature			
Regist	.1.0	DEC 0 4 2006 Blown It Aprendi			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 26 per me 9862 12-4-06 yt. State of Maryland / Department of Health and Mental Hygien@ () () () 1 - For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Year Davi Lee 25 2006 0500M NOV /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peartree Montgomery Spring SILVEY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day 3 - 19-6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State br Foreign **Funeral** Days 214-90-4060 Months Hours Min 1 MM 2□F Yrs. Director Usual Residence of Decedent 10b County 10a State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director REDERIC 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7105 CANTERBURY U-S-A Itеms 23a CT. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ es 2 ☐ No 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: þ Specify: WhITE 3 Widowed 4 Divorced "natural" Completed ! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) SEAMAN U.S. MERCHANT MARNE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDRAR LEE COILISON 19a. ormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 682 Color Valley CT. FRENCY MD, 21703
Date 20c. Location - City or Town, State Department of Health Important: If item 27 DEBCRAH M. Collison, SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ cremation 3 ☐ Removal from State ö TSREGISTAY ° 4 □ Donation 5 Other (Specify) 11-30-06 HANOVER, 22. Name and Address of Facility
Daugherty Family Funeral Home And Cremation Center, P.A. 21. Signatur any ir 2601 Mountain Road - Pasadena, MD. 21122 25. Part1. Enter the disease, o simplications that shock or heart failure. List only one caus that ex Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** CONVOVAS ensive disease or condition resulting in death) /Medical Due to (as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itilated events resulting in death) Last b. Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical attending p use as IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐ Pregnant at time of death 5 Other (specify) the i P.0. detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 🗌 Yes the Hospital or Attanding Physician: Be 25. Was case referred to medical gxaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home Sidence 6 XOther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 i es 2 □ No scene this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; After 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier 29c. License number 17 00428 29 1 m DWE 2006 Park meV 1 cal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 (2 / N BRECHER moomE 31. Date filed (Month, Day, Year) 32. Figistrar's Signature State

Registrar

DEC

04

2006

State of Maryland / Department of Health and Mental Hygien UU b For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Nov 29, 2006 8:50 A **Physician** Centar Margaret /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Clinton 8105 Woodyard Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours Yrs. 74 579 48 5428 Director May 30, 1932 Maryland Usual Residence of Decedent s filed within 72 hours after deeth with the Maryland if Hygiene. other than "natural", or items 23a or 28a-f ahow 10d. Inside City Limits 10c. City. Town or Location 10b. County id other then "natural", or items 23e or 28e-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2√☐ No Directo Maryland Prince George's Clinton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20735 United States 8311 Richardson Road Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give XX Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. δ ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Clerical 8th 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heath and Mental Hy important: if item 27 is marked other any injury or other traumatic avent, 9068. 17. Father's Name (First, Middle, Last) Hattie Hutchinson Norval Fulton Tippett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5530 A Franklin Blvd, Churchton, MD 20732 Virginia Lutz (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec 3, 2006 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Trinity Memorial Gardens Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lifersee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, MD 232 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myelocytic Leukemia **Physician** 6 moi Chronic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed ettending physicien end for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12\months?
1 \(\subseteq \text{Yes} \quad 2 \(\subseteq \text{No} \) 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 🛣 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No is effer deau...
rel Director: Affer this co...
in by the funeral director, pr 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Worker (Specify) Phew's Residence 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ceptifier 11/30 D14730 2006 who completed cause of death (Item 23a) (Type, Print) M.D., 8926 Woodyard Rd, #201, Clinton, MD 20735 David J. Haidak, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

06-09165							n Black I						
Helen Clark		. F 04-4-	State	of Marylaı				and Mer	ntal Hyg	iene		2001	5 38375
		l-For State Registrar			Ce	rtificate	of Death				9	200	
Physicia Medical Examin		1. Decedent's Name (First, Helen R. Cl)						Date of Deat Month December		Year	3 Time of Death 0745 hrs
	H	4a. Facility Name (if not ins		street and nun	nber)			vn, or Location	of Death			ounty of Death	1
)		7401 Willow Road	1				Frederi					lerick	
Funeral		5. Social Security Number	6. Se		7. Age (In yrs	last birthday) If Under Months	1 Year If Und Days Hour			•	Foreig	thplace (State or Washington
Director		213-42-6540	1	M 2XF	92		Yrs.			Sept.	2, 1	914 ^{Co}	untry) D.C.
ıy.		Usual Residence of Deceder 10a. State 10b. Co			10c City	, Town or Lo	ocation		<u> </u>	-			10d Inside City Limits
Maryland 28a-f show any <u>d at ouce.</u>			-										1 Yes 2 X No
ryland a-f sh	흱	Maryland Fre	ederic	: K	Mon	rovia	10f. Zip C	ode		10	g Citizen	of What Cou	ntry?
or 28	<u>.</u> 2		. Wis	Dedage			217	7.0			Inite	d Stat	AS
vith the s 23a s 23a e noti		4996 Linganor	e vie		dent Ever in U	l.S. 13	Was Decedent		igin? (Speci				ican Indian, Black,
eath v	Funeral	1 Never Married 2	Married	Armed For	rces?		If Yes, specify (Cuban, Mexica	n, Puerto Rio	can, etc.)		White, etc.	
ifter d	힑	3 X Widowed 4	Divorced	If Yes, Give Year		1	Yes 2	No specify	/.		Spe	ecify Wh	ite
ours a atura		15. Decedent's Education	(Specify or	ly highest grade	e completed)		dent's Usual Oo g most of working					of Business/	
6 an "n ical E		Elementary/Secondary (0-12)	College (1-	4 or 5+)			.5		,			Institutes
003 within tiene ner th Medi	Completed	17 Father's Name (First, M	iddle Last)	2		Con	tracts	18 Mothe	or's Name (Fi	irst, Middle, N	_	Health	
15-	BeC	Clarence Rol								Wines	laideir our	name)	
212 uld be Menta mark: even	<u></u>	19a. Informant's Name/Rela		ype, Print)	<u> </u>	19b. Ma	iling Address				ber, City o	r Town, State	, Zip Code)
MD 21215-0036 d 2 should be filed within 7 th and Mental Pygiene n 27 is marked other than numatic event, the Medica	_	Tina Gillian	n/Daug	hter		4996	6 Lingar	nore Vi	ew Dr	., Mon	rovia	, Mary	land 21170
l and l and Healt item	ı	20a Method of Disposition			01.11	crematory of	position (Name r other place)	-	Decer	nber	20c. Loca	ation - City or	Town, State
mor Pages ent of nt: 11		1 X Burial 2 Crer 4 Donation 5 Oth		Removal fro	m State Pa	rklawı	n Memor: rk	ial	6, 20		Rock	ville,	Maryland
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	t	21. Signature of Funeral Se		see		2	2 Name and Ad	ddress of Facil	ty Robe	rt A.	Pumph	rey Fu	neral Home/
		الصناك	بقا.	Δη.	M008	03	Rockvil Rockvil	le, Mar	yland	W2085	<u> 3°258</u>	5 mery	
Physician /Medical		23a Part I. Enter the disease failure. List only one of	ause on ea	ch line.				dying, such as	cardiac or re	espiratory arre	est, snock,	or neart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disor condition resulting in de-		Atherosclero			Disease	···					Deatri
			b	Due to (or as a	consequence	21).							
	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying C	9	Due to (or as a	consequence (of):							
	Examiner	(Disease or injury that initial events resulting in death)	ated C.	Due to (or as a	consequence of	of):							
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oe eve	dical	UNPENDED		AMENDED									
Box 68760, edeath certificate be the attending physicical for use as the burit		IF FEMALE: 23b. Was decedent pregnar	nt in the	23c. If yes, o	utcome of preg	nancy	F	3 Ector	oic pregnancy	.,	23d. D	ate of deliver	y Day Year
certif certif ending	cian	past 12 months?			nt at time of d	eath 5	Fetal death Other (Specif)		ne pregnancj	у	IVIO	1101	Day Teal
Boy death	ysi	1 Yes 2 V No 9	Unknown	9 Unknow	wn								
. ŭ . ŭ		Part II. Other significant c	onditions	contributing to	death but not	resulting in t	he underlying ca	ause given ın F	Part I.				the cause of death?
ires the signer is signer is signer in the signer is signer in the signer in the signer in the signer is signer in the signer in	d by									1 Yes			pably 4 🗸 Unknown
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Records, P.O. I The law requires that the cate has been signed by it page 2 should be detache	Completed									perfor		death? 1 ✓ Yo	es 2 No
	Be	25. Was case referred to m examiner?	_				26	Place of Death					
of Viting Physic	ၟႍ	1 🗸 Yes 2 N			npatient 2	ER/Outpat			Nursing F			6 🗸 Othe	Scene
ion of vending Pheath		27. Manner of Death 1 ✓ Natural 5	Pending	28a. Date of (Month,	of Injury Day,Year)	28b. Time	of Injury 28	c. Injury at Wo	_	3d. Describe h	iow injury c	occurred	
Siol Attended death death sector:	cati	2 Accident	Investigation	on 280 Place	of loury - At h	nome farm	street, factory, c			Rf Location (S	treet and I	Number or Ri	iral Route Number, City
Division of Vital Records, P.O. ral or Attending Physician: The law requires that trs after death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac	Certification:	3 Suicide 6 4 Homicide	Could not determined	be	or injury 7 kg	iome, iam,	511 001, 1d0(01), 0	moo banama,	510.	or Town, S			
Divisior Bospital or Attend 24 hours after death Funeral Director:		29a. Certifier	ing Physici	an: To the best	of my knowled	dge, death o	ccurred at the ti	ne, date and p	place, and du	e to the caus	e(s) and m	anner as star	ted.
Division of Vital Division of Vital Within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director.	Medical			On the basis o	f examination								
F % F 33	₹ E	29b Signature and title of	certifier					icense numbe	r		29d Date	e signed (Mo	nth, Day. Year)
9		and 2						D.C.M.E.			Decem	nber 3, 20	06
Ç	1	30 Name and address of p					n Stroot D-	ltimoro MA	21201		_		
V		Ana Rubio MD.		nt Medical E	xaminer gistrar's Signat		n Street, Ba	iumore, IVIL	J Z 1ZU I				
Sta Regist	ate rar	31. Date filed (Month, Day,	2006 £		giotiai o oigilai	Ess	S 9						
DHMH 17 Rev 1/20				9		ORIGI	NAI	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 8=15 Physician 4a. Facility Name (If not institution, give street and number) 28 /Medical 4c. County of Deat 4b. City, Town, or Location of Death Examiner Cos chuz Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 ☐ M 2 ☐ 8 November 24, 1925 193-20-0655 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nnent of Heatth and Mental Hygiene. and: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 24a or 28a-f show urry or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Randallstown Directo MD Baltimore COUNT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21/33 USA Court Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Constructor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DragoneHe Satherine Moser Nicholas ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) le Court ndallstown MO 21/33 Jackie Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If i any Injury or 106 4 □ Donation 5 □ Other (Specify) view Crenator 22. Name and Address of Facility 21. Signature of Funeral Service Licensee P.M 5 emile Hari Road, Battmore MO 21206-5105 5126_ Belour 23a. Part1. Enter the dillease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (Ir as a consequence of): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence f) Physician/Medical Examiner and and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy perform 1 Yes 2 No After this certificate funeral director, pag 2 🕽 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 우 Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No neral Director: A Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

			State of Maryland / Department of State of Maryland / Department of Certificate			ene 006	38377
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) ANGELO DIAZ.		2. Date of Death Month	Day Year 24 06	3. Time of Death Z: 17 AM
	Examin		HOWARD COUNTY HOSPITAL. Colu	wn, or Location of Death		4c. County of Death	COUNTY.
	Funeral Director		5. Social Security Number 118-44-7014 6. Sex 7. Age (In yrs. last birthday) 154 Yrs. 154 Yrs. Usual Residence of Decedent	Dave Hours Min	8. Date of Birth (Month, Day,) Mar8, 19	9. Birth Co. Sec. New	pplace (State or Foreign untry) York
	Maryland I e how	tor	10a. State 10b. County 10c. City, Town or Location Md. Baltimore Dundalk				10d. Inside City Limits 1 ☐ Yes ② No
	with the	Direc	10e. Street and Number 10f. Zip Co	ode 222	10	g. Citizen of What Cor USA	untry?
20	be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene. do other than "natural", or iteme 23e or 28e-f show event, the Medical Examinar must be notified at	by Funeral Director		nt of Hispanic Origin? (Sper Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.
0500-6171	within 72 hou ane. then "natura se Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 2 16a. Decedent's Usual C (Give kind of work of life. DO NOT use if Security	done during most of work retired)	ing	Bb. Kind of Business/I	industry
שם		Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	aiden Surname)	
2	2 should be and Mental le marked eumatic ev	10	Angelo Diaz, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (S	Americ	a Alvar al Route Number,		Tip Code)
e, K	es 1 and of Health of Item 27 r other tr		Noel Adamski 20a. Method of Disposition 1 Burial 2 **SCremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name cametery, crematory or othe Bayview Crem	er place)	Date 2	oc. Location - City or	
Баптіто	permit. Pag Department Important: I eny Injury o		21. Signature of Funeral Service Licensee 22. Name and A	Address of Facility a C	zorowsk	i Funera	
ı,		-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final Google Corporation			st,	Approximate Interval Between Onset and Death
	nysician /Medical Examiner		disease or condition resulting in death) a				
	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
09/89	ificate be e g physiciar as the buri	cal					
C. Box	that the death certificate led by the attending physic detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic preg 4 ☐ Pregnant at time of death 5 ☐ Other (speci			23d. Date of deli Month	very Day Year
1	sign d be	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying-cause Pen Blemal Wascular Buse of	se given in Part I.		cco use contribute to	the cause of death?
Vital Records,	The ate h	Completed			1	prior to death? No 1 □ Yes	topsy findings available completion of cause of
	Physician: r this certifica ral director, I	To Be	25. Was case referred to medical examiner? 1 \(\overline{\text{Yes}} \) 2 \(\overline{\text{No}} \) No Hospital: 1 \(\overline{\text{Inpatient}} \) 2 \(\overline{\text{EP/Outpatient}} \) 3 \(\overline{\text{DOA}} \)	Other: 4 Nursing Ho	h <i>Check</i> o <i>nly one</i> ome 5 ☐ Residen	ce 6 ⊡Other (Spec	cify)
o Lo	Attending Pt ir death. ector: After th by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	C. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division of	al or Atter after des f Director d in by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	office	28f. Location (Stre City or Town,	eet and Number or Ru State)	iral Route Number,
	To the Hospital or Attending if within 24 hours atter death. To the Funerel Director: Atter completely filled in by the funer	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.				
	To the within 2 To the complete	Me	29b. Signature and title of certifier A JAY SOUD AN	S940/.	29	d. Date signed (Mont)	h, Day, Year)
4	67		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATAY SOUDAN, MD, 8600 / 1588/Y/	59401. Rrad Ra	ndalls i	town, MI	21133
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 0 4 2006				

ORIGINAL

State of Maryland / Department of Health and Mental Hygierre 38378 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Michael R. Funk Month Year 29 1:00 NOV 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. AGNES HOSPI N/A TAL 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 2,1935 Birthplace (State or Foreign Country) **Funeral** 11 M 2□F Yrs Director 71 Maryland 213-32-2394 Usual Residence of Decedent 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Madical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? iteme 23a United States 21 Lombardy Drive 21222 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Ferral Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ MNo þ Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Letter Carrier Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Funk Rose Truffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Lombardy Dr. Dundalk, Maryland 21222 Mrs. Loretta A. Funk (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. 12/4/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** SEPSIS MKnown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ate has been signed to page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 50N'S 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D tinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 No Vital 1 Yes the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٥ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Division of After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after deat 3 ☐ Suicide 6 Could not be à Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Dire completely filled in by 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

TUNK, MICHAE

Registrar

FILENNE

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

32. Registrar's Signature

Cange California

NGOUMANO

DEC 0 4

COOOLIO

900 CATON Avenue, BATIMORE, MO 21229.

Nov 29,2006

06-08692 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Alvin Freeland 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Time of Death Medical Examiner November 15, 2006 0624 hrs Alvin Freeland 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death CSX Railway and I-695 Rosedale Baltimore County 5. Social Security Numberunk 6. Sex 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or unkIf Under 1 Year If Under 24Hrs 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. Director 1 X M May 31, 1958 Country) 48 Usual Residence of Decedent 10a. State unk 10b. County 10c. City, Town or Location 10d. Inside City Limits è unk unk unk Yes 2 No 28a-f show permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f chowingury or other traumatic event, the Madical 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' unk unk USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian Black unk If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. Never Married Yes No If Yes, Give Year 1 Yes 2X No specify: Widowed Divorced Specify: white þ Dates 16a. Decedent's Usual Occupation (Give kind of work done ${
m unk}$ 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) unk during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Compl unk unk 17. Father's Name (First, Middle, Last) unk 18.Mother's Name (First, Middle, Maiden Surname) unk æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ 19a Informant's Name/Relationship (Type, Print) O.C.M.E. 111 Penn Street Baltimore, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in state 21. Signatur of Euneral Sery e Sicensee de Wade 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street MD Baltimore Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ist only one cause on each line. Physician 23a Part I Approximate Interval Between Onset and /Medical Death Immediate Cause (Final disease Multiple injuries Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical g physician a the burial -XUNPENDED #23a,27,28a-f perME. IF FEMALE: 23d Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? \$ Yes 2 V No 3 Probably 4 Unknown Completed

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. certificate has To the Hospital or Attending Physician: Director: d in by the f To the Funeral

Be

Certification:

Medical

		24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
25. Was case referred to medical	26.Place of Death (Check	only one)
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin	ng Home 5 Residence 6 🗸 Other: Scene
27. Manner of Death	28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 5 Pending	(Month, Day, Year)	
2 Accident Investigat	ion [Find 11/15/2006] Find 6:11 am X	subject hit by train
3 Suicide 6 X Could not		28f. Location (Street and Number or Rural Route Number, City or Town, State) CSX Railroad and I695
4 Homicide determine	(Specify) railroad tracks	Rosedale, MD
OO- O-Milio-		

O.C.M.E.

November 15, 2006

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State Registrar

2. Registrar's Signature

Please Type or Print in Black Indelible Ink

Mary Viola Fenwi	ick	State of Maryland / Department 1-For State Amend Items 23e, 27, 29d periment	of Health and Mental Hygiene	Reg No 2006 3838
Physicia Medical Examin	n/	Decedent's Name (First, Middle, Last)	ENWICK 2. Date of De Month November	eath 3 Time of Death Day Year er 26, 2006 1124 hrs
		4a Facility Name (if not institution, give street and number) Bon Secours Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral		Social Security Number 6 Sex 7. Age (In yrs. last birthday)		Birth (MM/DD/YYYY) 9 Birthplace (State or
Director		ATT OF TASSET	Yrs. Months Days Hours Min.	1909 Foreign Country) MARYLAN
any	ł	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo.	cation	10d Inside City Limits
vlaryland 28a-f show d at once.	tor	MARYLAND N/A 10e Street and Number	BALTIMORE CIT	1 Yes 2 No
vith the Maryland s 23a or 28a-f shov notified at once.	Director	2627 RAYNER AVENCIE	21216	id SA
r death with or items 23	Funeral	1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Io- 14. Race - American Indian, Black, White, etc.
after de	by Fu	3 Widowed 4 Divorced If Yes, Grue Year or Dates:	Yes 2 No specify	Specify BLACK
72 hours after "natural",			dent's Usual Occupation (Give kind of work done gmost of working life DO NOT use retired)	16b Kind of Business/Industry
5-0036 led within 72 Hygiene other than the Medical	Completed	6 + HGRADE AR	TILLERY MAKER	TIN CAN MANUFACTURER
21215-i uld be filed Mental Hyg marked ott	Be	JOHN DORSEV	18 Mother's Name (First, Middle)	, Malden Surname) BARBER
Dre, MD 21215-0036 es I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene If item 27 is marked other than "matural", or items 23a or 28a-f she her traumatic event, the Medical Examiner must be notified at once	의	11111111	ling Address (Street and Number or Rural Route No.) 4 WESTWOOD AVE. BA	umber, City or Town, State, Zip Code)
- 9 - 9 - 8	Ì	20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or	position (Name of cemetery, Date	20c. Location - Lity or Town, State
Pag Pag nent ant:		4 Donation 5 Other Specify: BALTIM	ORE NATIONAL 12-01-06	BALTIMORE, MD
Balti permit Departri Importi injury c	1	21. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee	2. Name and Address of Facility TOSE PH H. BROWN 2.140 N. FULTONAVE.	JR. FUNERAL HOME BALTO, MD 2/2/7
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.		
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cal	diovascular Disease	Deatti
San San San San San San San San San San	Je	Sequentially list conditions, if any, leading to immediate but to (or as a consequence of):		
	Examiner	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		
and	dical E	d AMENDED		
be be	š١	123c If yes, outcome of pregnancy		23d. Date of delivery
Box 6876(c death certificate the attending phys	sician	past 12 months? 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Other (Specify)	Month Day Year
e E e m	튑	1 Yes 2 ✓ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I 23e. Did	tobacco use contribute to the cause of death?
s, P.O. uires that then signed by lid be detach	ed by			es 2 No 3 Probably 4 X Unknown
Division of Vital Records, rat or Attending Physician: The law requirers after death all Director: After this certificate has been siled in by the funeral director, page 2 should be a bound the funeral director, page 2 should be a sho	Completed			ppsy prior to completion of cause of ormed? death?
tal Rec	Be Co	25 Was case referred to medical	26.Place of Death (Check only one)	2 No 1 Yes 2 No
of Viting Physici	၉	examiner? 1 Ves 2 No 1. Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of		Residence 6 Other
ion of vending Pheath	ation:	1 Natural 5 Pending Nov 23, 2006 1330 hrs	1 Yes 2 No	now injuly occurred
Division At pital or At ours after deral Direct filled in by	Certification:	3 Suicide 6 Could not be determined	or Town,	
Divisior To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ		Avenue, Baltimore, MD use(s) and manner as started.
To the within To the comple	Medical	 one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated 29b. Signature and title of certifier 	gation, in my opinion, death occurred at the time, date	e and place, and due to the cause(s) 29d Date signed (Month, Day, Year)
		ane R	O.C.M.E.	November 27,2006
4		30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimo	ore. MD 21201	-1
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		
Registr	rar	DEC 0 4 2006 DECINE A ACCOUNT		

State of Maryland / Department of Health and Mental Hygiene [38381 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yeer November 30, 2006 **Physician** Ann L. Frazier 10:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1709 Henry Road Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 21, 1 9. Birthplace (State or Foreign Country)
West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours 1□M 2XF 72 Yrs. 579-42-7990 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland I Hygiene.
other than "natural", or Itama 23a or 28a-1 ahow 10c. City, Town or Location 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: if Itam 27 is marked other than "natural", or Itams 23s or 28s-1 show ury or other traumatic avent, the Medical Examinar must be notified at 1√2 Yes 2 □ No Funeral Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20851 United States 1709 Henry Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pauline Moulden Oliver Q. Harden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 17733 Cliffbourne Lane, Derwood, Maryland Michael Ray Frazier/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Memorial Date 20c. Location - City or Town, State 20a. Method of Disposition December 4 Burial 2 Cremation 3 Removal from State Park 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
MO0803 Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805 permit. Page Department of Important: if any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Suneral Service Licensee DOC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine as been signed by the attending physicien and 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 Yes 2 No 37 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes Y □ No 24a. Was an autopsy performed? page this certificate 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Dther: 4 Nursing Home 5 X Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of pertifier, D0062234 December 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Manish Agrawal, 31. Date filed (Month, Day, Year) 9707 Medical Center Drive, #300, Rockville, Maryland 20850 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

DEC 0 4 2006

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Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Johnathan Keith Frver 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day November 29, 2006 1725 hrs Medical Examiner Jonathan Keith Fryer 1c County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Gaithersburg 136 Goucher Terrace If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** oreign Months Days Hours Country) Florida Director March 20, 1973 33 1 X M 256-55-3033 2 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10b County 1 X Yes 2 No 28a-f show Gaithersburg Maryland Montgomery 23a or 28a-f sho notified at once. death with the Maryland 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code United States 20877 136 Goucher Terrace Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black or items 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 1X Yes Yes, Give Year Yes 2 X No specify 3 Widowed Divorced Specify: 4 **Black** natural", à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 h Department of Health and Mental Hygiene Important: If item 27 is marked other than in jury or other traumatic event, the Medical E. 2 should be filed within 72 h h and Mental Hygiene 27 is marked other than "n matic event, the Medical E Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Navy Registered Nurse 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ossie O. Blount Johnny A. Fryer Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 136 Goucher Terrace, Gaithersburg, MD 20877 April L. Fryer / wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dec. Date Burial 2 X Cremation 3 Removal from State 2006 Montgomery Crematorium, Inc Bethesda, Maryland Donation 5 Robbert and Administrativy Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Serv e Licenbee M00896 7557 Wisconsin Ave., Bethesda, Maryland 20814 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Between Onset and List only one cause on each line failure. /Medical Death Mixed drug (oxycodoen, hydrocodone, acetamino hen) and alcohol tue to (or as a consequence of): intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED AMENDED #23a,27,28a-f g862, 12/11/06 TT perME. Box 68760 23d. Date of delivery IF FEMALE: 23b Was decedent pregnant in the 23c. If ves. outcome of pregnancy 3 Ectopic pregnancy Year Live birth Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. à 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 1 🗸 Yes 2 28c Injury at Work 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of Injury Certification: Natural 5 Y Pending within 24 hours after death To the Funeral Director; Fnd 11/29/2006 Fnd 5:00 pm 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 136 Goucher Terrace 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide (Specify) found in residence determined Gaithersburg, MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier O.C.M.E November 30, 2006 30 Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Mides & -آنار

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38383 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Steven W Gilberto, SR. 2:30 PM 29 2006 NOV /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA University of Maryland Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 53 214 62 0667 May 21, 1953 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eximiner must he provided once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XINo Anne Arundel Glen Burnie Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 20 Ridge Road 21060 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 7 th College (1-4or 5+) Mechanic / Auto Body Auto Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gloria Hoover Augestine Gilberto ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Gilberto / Son 24 Stone Drive Pasadena, Maryland 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 TBurial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 12/03/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Fundral Service Licens 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart failure /Medical Due to (or as a consequence of): **Examiner** Schemic Cardiomyopathy if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician; The law requires that the death certificate be executed and as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Nonknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To nours after death.

neral Director: After this
filled in by the funeral d 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Nayah MD. P21212 Nov 29 2006 allma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S Greene Street Baltimore MD 21201 Seema Nayax 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

06-08971 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Timothy Glasheen 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Date of Death Physician/ Month Day November 25, 2006 0602 hrs Medical Examiner Timothy Michael Glasheen 4c. County of Death 4a Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death Montgomery Suburban Hospital Bethesda 9. Birthplace (State of 5. Social Security Number 6 Sex 7 Age (In yrs last birthday) If Under Year If Under 24Hrs. Date of Birth (MM/DD/YYYY **Funeral** Foreign Maryland Min Months Days Hours Director January 9, 1953 1 X M 53 Country 219-46-5021 2 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b. County 28a-f show Yes 2 X No Bethesda Maryland Montgomery hours after death with the Maryland Director 10e. Street and Number log. Citizen of What Country 10f. Zip Code or items 23a or 28a-20814 United States 7620 Old Georgetown Road, #1029 Funeral Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married Armed Forces? 2 X No Yes White 1 Yes 2 X No specify: Yes, Give Year Widowed Divorced Specify "natural", ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) ages I and 2 should be filed within 72 rt of Health and Mental Hygiene. event, the Medical None None 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Frances Tucker John D. Glasheen 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7620 Old Georgetown Road, #1029, Bethesda, Maryland 20814 Frances T. Glasheen / Mother 20a Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State Baltimore, crematory or other place) December Burial 2 X Cremation 3 Removal from State Pages 1 1, 2006 Montgomery Crematorium, Inc. Bethesda, Maryland Donation 5 Other Specify. injury Signature of FunerahService Licensee 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. (attex)amo M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a Methadone intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or Tijury that initiated Due to (or as a consequence of) events resulting in death) Last and transit #28f, perME, g862, 12/22/06 TT 28f per me g862 #23a,2<u>7,28a</u>-f, perME, g862, 12/14/06 TT Physician/Medical X UNPENDED ·22 vt physician the burial -Box 68760, IF FEMALE: If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. þ Yes 2 No 3 Probably 4 🗸 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes After this certificate 25. Was case referred to medical 26 Place of Death (Check only one Division of Vital Be Hospital 1 Other₄ Inpatient 2 CR/Outpatient 3 DOA Nursing Hame 5 Residence 6 1 🗸 Yes 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Natural Pendina the Fnd 11/25/2006 unknown Director: unknown Investigation Accident Location (Street 46444 mber or Rural Route Number, City or 7625 Date) 7621 Old Georgetown Rd. 28f Location (Street and 44) 28e Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide within 24 hours a

To the Funeral I determined (Specify) other-scene 1029 Bethesda. Homicide MD Apt. 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E November 25, 2006 a

DEC 6 31. Date filed (Month

Name and address of person who completed cause

Zabiullah Ali, M.D.

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Le Ih (Item 23a)

Assistant Medical Examiner

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Kathleen P. Haight 8:30a December 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Carroll Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthptace (State or Foreign Country) **Funeral** 1 □ M 2√□ F Director 212-05-0471 Apr 29 1910 MD Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location ir than "natural", or items 23a or 28a-1 show tra Medical Exaction most be nutified at 10d, Inside City Limits Carrol1 Westminster MD Be Completed by Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4536 Salem Bottom Road 21157 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or items 23.
ury or other traumatic event, the Meulcal Exacutiver transit 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify. Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cottege (1-4or 5+) Elementary/Secondary (0-12) school teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edgar E. Pickett Bertha B. Buckingham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4127 Twin Arch Rd., Mt. Airy, MD 21771 19a. Informant's Name/Relationship (Type, Print) Todd Buckman (grandson) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: if any injury or pnon. Old Oakland Cemetery 12-6-06 Sykesville, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of). Examiner BOWEL (HEMIC Sagrentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, deretic 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 10 No 2 ER/Outpatient 3 DOA this nours after death.

neral Director: After this

filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 - Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Qay, Year) witadedu Neckanny DO018200 1213100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 A poole Rd WESTMINSTER NBCITNNA CHITRACHED L 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 0 4 2006

ORIGINAL

			For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artmer rtifica:	nt of H	ealth an D <i>eath</i>	d Mer		gieng Reg. No.	006	383	86
, se		r	1. Decedent's Name (First, Middle, Last)					-		Date of Dea		Year	3. Time of I	
	Physici /Medic		Elizabeth W							cembe			12:30p	, M
	Examin	er	4a. Facility Name (If not institution, give str			4b. City		Location of D				County of Deal		
			Fairhaven Health Ca 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthdav)	If Unde	r 1 Year	ykesvi] fUnder24	Hrs. 8.	Date of Birt	h	Carroll	thplace (State or	Foreign
	Funeral Director			^{M 2□F} 94	Yrs.	Months	Days	Hours	vin. J	Month, Day une 2	y, Yea <i>r)</i> 6 , 1	912	MD	
	P .		Usual Residence of Decedent	10. 0	Y								10d Incide Cib	Limita
	1215-0036 within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Modical Exerciner ruset by notified at	_	MD County Carroll	10c. Cii	y, Town or Lo Sykes		_						10d. Inside City	
		ecto	10e. Street and Number		Dynci		p Code				10a. Citi	zen of What Co		
with 3a of		7200 Third Avenue					1784			-	USA	,		
	ms 23	Funeral Director		2. Was Decedent Ever in U	.S. 13.	Was Dece		ispanic Origin n, Mexican, P	? (Specify	Yes or No		14. Race - Ame Black, Whit		
36	irs after	ğ	1 ☐ Never Married 2 ☐ Marned 3 🖫 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes		Specify:	derito Frioc	11, 010.7		Specify: W		
21215-0036	72 hou	Completed	15. Decedent's Educa (Specify only highest grade		16a. Dece			ation during most of	working		16b. Ki	nd of Business	/Industry	
21	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT I	ise retirec)	g					
12	led w tygier her th		17 Fether's Name /First Middle / ast)	4		Te	ache:		Name (Fi	rst Middle		ucation	1	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan popuration of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or itams 23s or 28s-1 show eny injury or other traumatic event, the Medical Examination with the multiple at once.	To Be	17. Father's Name (First, Middle, Last) John Wise					18. Mother's Name (First, Middle, Maiden Sumame) Elizabeth Michael							
		19a. Informant's Name/Relationship (Type Mr. Edward E. Grove			•		a <i>nd Number</i> o e, Mart			-	r Town, State, I 5401	Zip Code)		
	f Hea item other		20a. Method of Disposition	20b. F	Place of Dispo cemetery, cre-				Date	,		cation - City or	Town, State	
altimore,	Page nent o int: If iry or		1 Burial 2 Cremation 3 Re- 4 Donation 5 Other (Specify)	moval from State Lal	ke Viev	v Mem	. Pa:	rk 12	2/6/2	006	Syke	sville,	, MD	
Balti	permit. Departn imports eny inju		21. Signature of Funeral Service Licensee	Haiget	I I	2. Name a HAIGH Sykes	nd Addre	SS of Facility NERAL F	HOME	& CHA	PEL.	PA (Bo 5-1400	ox 195)	
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O. Box	he death certificate be executed the attending physicien and thed for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta	Live birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify)				Month			Day Year		
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uo	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time o Injury		м	28c. Injur Wor 1 🗍	k?" Yes 2 □ No		28d. Describe how injury occurred				
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	St. Regist	ate rar	31. Date filed (Month, Day, Year) DEC 6 4 2006	32 Registrar's Sign	ature	cells)								

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

AMEND ITEM#17, perith, 682, 12/7/6, WS
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Cleo Elizabeth Heath **Physician** Month 7:27 AM November 29 2006 /Medical 4a. Facility Name (If not institution, give street and number) Washington County Hospital 4b. City, Town, or Location of Death Hagerstown 4c. County of Death Washington Examiner Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) **Funeral** 219-12-9072 1 □ M 2 🔀 F Director 82 06/09/1924 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: If tiern 27 is a marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Hagerstown 1 ☐ Yes 2 ▼No Director Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 847 Pine Street 21740 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify. White Completed by lf Yes, Give Year or Dates: 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Phone Company Operator 12 17. Father's Name (First, Middle, Last)
George Leonard Carrison 18. Mother's Name (First, Middle, Maiden Surname) Be Irva (Unknown Surname) ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard G. Heath/Son 7913 Red Globe Court, Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/03/2006 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland ^{22. Name and Address of Facility} Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Signatu of Funeral Service Licenses any In 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY **Physician** /Medical Due to (or as a consequence of): **Examiner** CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ATRIAZ burial-trar Due to (or as a consequence of): Physician/Medical ALTERED IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à TRACT INFECTION 1 Yes 2 No 3 Probably 4. Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide hours after 29a. Certifier 🛮 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

State Registrar

AGTALO DAVID 31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



251

00062006

EAST ANTIETHM ST. HALIGRITOWN

	Registrar		C	ertificate of	Death		Reg. No.	2006	3838
ian cal	Decedent's Name (First, Middle, Las Marie B. Henderson Facility Name (If and institution arises.)		to al	Ab Cib. Town	at against of Doot	2. Date of De Month	Day 01	Year 2006	3. Time of Death 09:15
ner	4a. Facility Name (If not institution, give Holly Hill Manor, Inc.	•		Towson	r Location of Deat		Balt	County of Death	
	5. Social Security Number 6. Social Security Number 1 213-03-9493 Usual Residence of Decedent	ex □M 2 X F	7. Age (In yrs. last birthda Yrs.	Months Days	If Under 24 Hrs Hours Min.		ay, Year)	Coui	place (State or Forei ntry) more, MD
'n	10a. State 10b. County		10c. City, Town or	Location				1	1 ☐ Yes 2
Director	MD Baltimore 10e. Street and Number		Towson	10f. Zip Code			10g. Citiz	en of What Cour	
Funeral	49 Acorn Circle 11. Marital Status 1 □ Never Married 2 □ Married	Armed Ford	2. [X î No	3. Was Decedent of H If Yes, specify Cub		Specify Yes or No to Rican, etc.)	U.S.A.	4. Race - Americ Black, White,	
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Completed	Elementary/Secondary (0-12) 7 17. Father's Name (First, Middle, Last)	College (1-	40r 5+)	emaker		me (First, Middle		Home	
To Be	Joseph Haubner				Marie Mar	ntel			
	19a. Informant's Name/Relationship (7) Paulette Newberger			iling Address (Street Arnhem Road				Town, State, Zip	Code)
	20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐	Removal from S	20b. Place of Dis	position (Name of rematory or other place	ce)	Date		ation - City or To	own, State
	4 Donation 5 Other (Specify) Hilltop Service Corp. 12/04/2006 Toward Service Licensee 22. Name and Address of Facility Leonard J. Ruck, 5305 Harford Road Baltimore, MD 212								
	Immediate Cause (Final disease or condition	WILL		_					Approximate Interval Between
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06-08616 Victor E Hernandez

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 2006 38389

		I- For State Registrar	Certifica	ite of Death	Reg	No.	7 0000			
Physicia	an/	Decedent's Name (First, Middle,Last)			Date of Death Month November	Day Year	3. Time of Death 1221 hrs			
dical Exami		Victor E. Hernand		12, 2006 4c. County of Death	1221 11(5					
		4a. Facility Name (if not institution, give Johns Hopkins Bayview Me		4b. City, Town, or Location of De Baltimore	eatn	4c. County of Death				
					Hrs 8 Date of Birth	(MM/DD/YYYY) 9. Birt	holace (State or			
Funeral Director		5. Social Security Number unk 6. Sex		Months Days Hours	Min	Foreig	n			
Director			и 2 F 19	Yrs.	Sept 13	, 1967	untry)Maryland			
ź	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			10d Inside City Limits			
_ 04 a				Baltimore			1 Yes 2 No			
yland a-f sh	흱	MD 10e. Street and Number		10f. Zip Code	100	Citizen of What Cour	itry?			
e Mai	Director	210 N. Streeper S	Street	21224		USA				
eath with the Maryland items 23a or 28a-f show any ust be notified at once.	L	11. Marital Status	12. Was Decedent Ever in U.S.	13 Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - Ameri	can Indian, Black,			
or items	Funeral	1 X Never Married 2 Married	Armed Forces?	If Yes, specify Cuban, Mexican, Pu		White, etc.				
p to		3 Widowed 4 Divorced	1 Yes 2 X No	1 X Yes 2 No specify me	xican	Specify: W	hite			
136 hin 72 hours afte e. than "natural", edical Examiner	d b	15. Decedent's Education (Specify only		Decedent's Usual Occupation (Give kind		16b. Kind of Business/I	ndustry			
72 ho n "na al Ex	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working life. DO NOT use	retired)					
036 ithin ne. ne. r than	Completed	8	0	none		none				
215-0036 ntal Hygiene. red other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last)		18.Mother's N	ame (First, Middle, Ma	aiden Surname)				
21215-0036 Juid be filed within 72 hours after Mental Office of other than "natural", ic event, the Medical Examiner	Be	Victor E. Her		D. Mailing Address (Street and Number	isa D. Spa	angler	Zin Code)			
· 4 = ~ 0	입	19a. Informant's Name/Relationship (Ty								
MD nd 2 sho alth and om 27 is raumati		Betty Spangler/gr 20a. Method of Disposition		210 N. Streeper St	reet Balt:	20c. Location - City or	21224 Town, State			
of He		1 Burial 2 X Cremation 3	Removel from State cremat	ory or other place)	12/9/06	Odenton, MD				
Page ment tant: or of		4 Donation 5 Tother Specify	in state				RATITION DIE			
Baltimore, pernit. Pages I ar Department of Hee Important: If ite		Donation 1 History Specify in state 21 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 22 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 23 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 24 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 25 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 26 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 27 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam and ddres of Facility Porton Bailey Fineral 2818 . RATTITIPE 28 Nam a								
	2	23a. lart I. Enter the disease, or complete	ations that caused the death. Do no	1 Roltimore MD 5 of enter the mode of dying, such as cardi	ac or respiratory arre	LINDRE, MI ZIZ	Approximate Interval			
Physician /Medical	1000	Mure List only one cause on each	ch line.				Between Onset and Death			
xaminer			Narcotic (methadone) Oue to (or as a consequence of):	intoxication						
		h	de to (or do a correctación o o.).							
	je		Due to (or as a consequence of):							
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of):							
xecuted n and - transit	Ä	events resulting in death) Last d.	sac to (or as a consequence or).							
8760, inficate be executed mg physician and as the burial - transi	ical		AMENDED #20a-c,22,p	erFH.C862,12/28/06,WS perME G862, 12/21/06						
18760, rificate be exering physician as the burial -	n/Medical	IF FEMALE:	#23a,27,28a=	perric 6002, 12/21/00	11	23d Date of deliver	<u> </u>			
		23b Was decedent pregnant in the past 12 months?		Fetal death 3 Ectopic pr	egnancy	Month (Day Year			
Box 6 e death cer the attendi ed for use	sici	1 Yes 2 No 9 Unknown	4 Pregnant at time of death 9 Unknown	Other (Specify)						
Records, P.O. Box 6 The law requires that the death cer cate has been signed by the attendi sage 2 should be detached for use	Physicia	Part II. Other significant conditions		g in the underlying cause given in Part I.	23e. Did tok	pacco use contribute to	the cause of death?			
P.O. that the head by detact	ğ	Turch. Other signmount continues		g		2 No 3 Prol	oably 4 🗸 Unknown			
S, I quires en sig ald be	ted					n 24b. Were au	itopsy findings available			
OFC aw re- nas be 2 shor	e				autops perfori		completion of cause of			
Rec The I cate I	Completed				1 ✓ Yes 2	No 1 🗸 Y	es 2 No			
tian: certif ector,	Be (25. Was case referred to medical examiner?	ospital:	26.Place of Death (Chautpatient 3 DOA Other		Residence 6 Othe				
of Vital Records, P.O. Box 6 ing Physician: The law requires that the death cer After this certificate has been signed by the attendifuneral director, page 2 should be detached for use	ူ	1 ✓ Yes 2 No	i inpatient 2 V ER/C	Time of Injury 28c. Injury at Work?		ow injury occurred				
		27. Manner of Death 1 Natural 5 Pending	(Month, Day, Year)	1 Ves 2 V No	, .	,				
SiO Arten death ctor:	[ati	2 Accident Investigation	28a Place of Injury - At home	arm, street, factory, office building, etc.		treet and Number or Ri	ural Route Number. City			
Divisior ospital or Attend hours after death uneral Director: y filled in by the	Certification:	3 Suicide 6 X Could not 1 determined	pe	arm, stroot, ruotory, office building, etc.	or Town, St Baltimore	ate) 210 N. St	ural Route Number, City reeper St.			
file ou pi		4 Homicide	residence	eath occurred at the time, date and place			ted			
To the Hos within 24 h To the Fun	Medical	Charle anti-	:On the basis of examination and/or	investigation, in my opinion, death occur	red at the time, date a	and place, and due to the	ne cause(s)			
= = = =	- :≛	2 V Modrout Examination	and manner stated							

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) November 13, 2006

ST.

Name and address of person who completed the of death (Nem 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend #19a Per State of Maryland & Per FH G862 12/04/06 ertificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 30 AM 11 20 VON 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WAESCHE BOWIE PRINCE GEORGE DRIVE If Under 1 Year 8. Date of Birth (Month, Day, Year) 01 · 28 · 1945 If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** -+€ M 2 XX Months Days Hours Min 212-42-0570 Director mo Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eatth and Mental Hygiene. 10c. City. Town or Location la or 28a-f show be notified at 10a State 10h County 10d. Inside City Limits BONLIE 1 □Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a cluer must be WAESCHE. USA 11528 DRIVE 2072 Funeral 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify Specify: BLACK þ 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 YRS COMPTROUGR COULBE 12/14 GRAVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LAWRENCE QUEEN ANNA HINES 2 19a. Informant's Name/Relationship (Type. Print(Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , MD 21409 DAUGHTER 1538 HICKORY WOOD DR., ANNAPOLIS GREEN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) REST CEMETERY 11.27-06 HANOVER. ure of Funeral Service Licen 21. Sign 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 5151 BALTO. NATT PIRE, BALTO. MD 21229 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and I-tran Due to (or as a consequence of) physician a Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24a. Was an autopsy performed/? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has e 2 page certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) War 020396 106 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID HAHN 201 E. UNIVERSITY PKWY. BALTO. 21218

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2006

Registrar's Signature

Ctata of Mandand / Dan	
State of Maryland / Deb	riment of Health and Mental Hydiene/
otato of many aria, bop	rtment of Health and Mental Hygiene2 U

For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ²29, 2006 **Physician** November Gertrude M. Hennessy 8:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 ☑ F Yrs. Director 085-10-2252 99 June 3, 1907 New York Usual Residence of Decedent the Marylend 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or Itams 23a or 28a-f ahow traumatic evant, the Madical Examinar must be notified at Directo 1 ☐ Yes 21 No Maryland Montgomery North Potomac 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 2, any injury or other traumatic event, the Modical Exempted 2009. 10f. Zip Code 10g. Citizen of What Country? 13520 Travilah Road by Funeral 20878 United States Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Investment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ William Vorgang Elizabeth Schweitzerhof 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Welty/Granddaughter 13520 Travilah Road, N. Potomac, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Staten Island, New York 4 ☐ Donation 5 ☐ Other (Specify) 4, 2006 St. Peter's Cemetery 21. Signature of Funeral Service Lin nsee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc., 300 West Montgomery Avenue, M01473 Rockville, Maryland 20850 23a, Part1, Enter the disease r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, t only one cause on each line. Approximate Interval 8etween Onset and Death shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Pnysician Hypertensive Heart Disease /Medical Due to (or as a consequence of): Examiner Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien and s the burial-transit Dementia Due to (or as a consequence of): Box 68760, Physician/Medicai use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 □Ectopic pregnancy for Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. sete has been signed by the pege 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? Division of Vital Records, δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificete has 1 ☐ Yes 2 🖾 No 1 Yes 2 No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funerel Director: Af completely filled in by the fu death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MOSUNU Womens D0047330 November 30, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Thomas V. Joseph,

31. Date filed (Month, Pay, Year)

M.D.

32. Registrar's Signature

50 West Edmonston Drive, #207, Rockville, Maryland 20852

06-08908 Please Type or Print in Black Indelible Ink Maryland / Department of Health and Men lygiene Mari Anne Jones 38392 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day November 23, 2006 0546 hrs **Medical Examiner** Marianne Jones 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Rockville 13310 Ardennes Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Days Director Country) 1959 WA 17, 2 X F 47 Nov. 1 M 185-48-5559 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County s 23a or 28a-f show e notified at once. 1 X Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. MD Montgomery Rockville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 13310 Ardennes Avenue 20851 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No 1 Yes If Yes, Give Year 1 Yes 2 No specify: Specify: White 4 Divorced 3 Widowed ģ Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) or other traumatic event, the Medical Realtor Real Estate 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Curtin Mort Jones Mary Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Vensel/Husband 13310 Ardennes Ave., Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State timore, Metropolitan Burial 2 X Cremation 3 Removal from State Department o 11-29-06 Crematory Alexandria, VA Donation 5 Other Specify permit. 22. Name and Address of Facility ignature of Funeral Service Lidensee Young Funeral Home, LTD PO Box 1522, Butler, PA 16003 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disease, or **Physician** failure. List only one cause on each line. /Medical Death a. Contact Gunshot Wound to Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last certificate be executed Physician/Medical UNPENDED **AMENDED** attending physician or use as the burial Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ Yes 2 No 3 Probably 4 Unknown Completed Records, 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No this certificate 26, Place of Death (Check only one) the Hospital or Attending Physician: 25 Was case referred to medical of Vital æ examiner? Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 Yes 28a. Date of Injury FOUND: Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 27. Manner of Death Certification: Subject shot self FOUND: To the nosperation 24 hours after death To the Funeral Director: A Natural 1 Yes 2 ✔ No Division Pending Nov 23, 2006 0540 hrs 2 Investigation Accident 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 13310 Ardennes Avenue, Rockville, MD determined (Specify) Single Family 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie O.C.M.E. November 23, 2006 30. Name and address of person who completed cause of death (Item 23a) Debuty Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD. 31. Date filed (Month, Day, Year) State 0 4 Registrar

06-08709 Robert Jones Please Type or Print in Black Indelible Ink.

AMEN DEPARTMENT OF Health and Mental Hygiene
State of Maryland 7 Department of Health and Mental Hygiene

		1- For State Registrar		Certificate	of Death		F	leg. No. 20	06 3839
Physici Medical Exami		Decedent's Name (First, Middle, Decedent's Name (First, Midd					Date of Dea Month	Day Year	3 Time of Death 2022 hrs
- ·	1101	Robert Jor 4a. Facility Name (if not institution,		,	4b. City, Town,	or Location of D		r 15, 2006	
		Mercy Hospital			Baltimore				
Funeral Director		5 Social Security Number unl		rs. last birthday)		ear If Under 2 ays Hours	Adim		9. Birthplace (State orunk Foreign
Director		094–48–0805 Usual Residence of Decedent	1X M 2 F	50	Yrs.		July	1956	Country New York
auò		10a. State unk 10b. County	unk 10c. (City, Town or Lo	cation			un	10d Inside City Limits
laryland 8a-f show at once.	ō	MD		Baltimo	ore				1 X Yes 2 No
Maryl r 28a-1	Director	10e. Street and Number		-ur	10f. Zip Code		unk	10g Citizen of Wha	at Country?
ith the M 23a or 2 notified		2514 N. Ellamon		n II C 12	2121		? (Specify Yes or No		SA
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Memal Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	uneral	1 Never Married 2 Mar	1 4	unk	If Yes, specify Cub			White,	American Indian, Black, etc.
after c	by F		ced If Yes, Give Year or Dates:	1[Yes 2X			Specify: 1	lack
hours 'natur	eted	15. Decedent's Education (Specific Elementary/Secondary (0-12)		d) 16a. Deced	dent's Usual Occup most of working I	oation (Give kind ife, DO NOT use	d of work don eunk e retired)	16b. Kind of Bus	ness/Industry unk
0036 within 72 iene. er than '	omple	unk 12	College (1-4 or 5+) unk 0	Logg	Preventi	on Spec	eialict	Forem	an Mills
5-0036 iled within 72 Hygiene. I other than the Medical	O	17. Father's Name (First, Middle, L		IJOBB	unk	18.Mother's N	lame (First, Middle,	Maiden Surname)	unk
2121 uld be fil Mental F marked c event, 1	Be	Jack Jones	(T	T roy 11			ie Walker		
and 2 should be feath and Memal tem 27 is market traumatic event.	ဥ	Variyce Jones/sp	Duse	251	4 N. EII	amont A	rorRuralRouteNur Ve Bal altimore,	nber, City or Town Linore , M	P ₁ 21216
3 n at u		20a. Method of Disposition	20	Db. Place of Disp	osition (Name of		Date		City or Town, State
More, Pages 1 a nent of He ant: If ite		1 XBurial 2 Cremation 4 Donation 5 X Other Spec	Removal from State	crematory or YFRES III Mt. Zion	Com	_	-12/9/06 2/11/2006	POCKLEN,	NY.
Balti permit. Departm Imports injury o		21. Signotur - Truneral Pervice Li Ron 11d S	censue?	22	Name and Addre	ess of Facility	WELL F/H .4	Landsdowi 600 LIBERI	Y'HGHIS.
	4	Juni &	VI Call	13	altimore	, MD 2	1 201 FALTO ,	MD 21207	re Street
Physician /Medical		23a. Pakt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Proceedings Approximate Interval Between Onset and Death							
Examiner		Immediate se (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Death Due to (or as a consequence of):							
	Ļ	Sequentially list conditions, b.							
-,	nine	Due to (or as a consequence of): (Disease or injury that initiated c							
led led	Examiner	events resulting in death) Last	Due to (or as a consequence	ce of).		···	-		
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Di To the Hospital within 24 hours a To the Funeral I completely filled	Medical	Check only criting	ner: On the basis of examination and manner stated.	n and/or investig	gation, in my opinio	on, death occurr	ed at the time, date	e(s) and manner as and place, and due	s started. to the cause(s)
F 3 F 3	₩ E	296. Signeture and title of certifier	And marrier stated.		29c. Licer	nse number		29d. Date signed	(Month, Day, Year)
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((3)		Name and address of person wi			n Stroot Bell	imore MD C	21201		
	ate		istant Medical Examine		n Street, Balt	imore, IVID 2	1201		
ટા Regist	rar	31. Date filed (Month, Day, Year) DEC 0 4 7	32 Registrar's Sign	St. Box	enter				

State of Maryland / Department of Health and Mental Hygiene 38394 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 29, Month **Physician** Kirschner November 6:25 PM 2006 Mary Jane /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Co. Edgemere 8910 Avenue B If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 21,1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1 M 2 F Hours Yrs Director Virginia 89 214-38-3670 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Fleath and Mental Hygiene. Item 27 is marked other than "natural", or itema 23s or 28s-1 show other traumatic event, it a Medical Examinar must be inclined at 10b. County 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Edgemere 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8910 Avenue B 21219 United States Funera Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int. If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify. Specify. Completed by 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore V.A. Medical Secretary 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecile Porter Iver D. Williams ٥ 19a, Informant's Name/Relationship (Type, Print) (SOn) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) North East, Maryland 21901 54 Hickory Drive Mr. Thomas J. Kirschner, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō I ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: if eny injury or once. Hilltop Service Corp. 12/4/2006 Towson, Maryland 4 Qonation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myo and /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical ettending phys for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the e 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 Yes 2 No 1□ Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After the Hospital or Attending Injury 1 Matural 5 Pending 1 Tes 2 No 24 hours after death.

Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho

To the Function 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tille of certific 29c. License number 29d. Date signed (Month, Day, Year) November 30, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7566 N. Point Rd 31. Date filed (Month, Day, Year) @32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

DEC 0 4 2006

DHMH 17 Rev 1/2001

State Registrar

Da 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

080

32 Registrar's Signature

Division or Vital Records, To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After

DHMH 17 Rev 1/2001

State Registrar (Check only one)

29b. Signature and title of ortifier

31. Date filed (Month, Day, Year)

JOHNS HOPKINS

DOCTOR

HUSFITAL, 600 NURTH WOLFE STREET,

29c. License number

MAULIK

RES-000

MAJMUJAR

BALTIMORE,

29d. Date signed (Month, Day, Year)

NOVEMBER 30, 2006

MARYLAND 21287

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEDILAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year ELWOON OWARD STER 7:00 AM Dec 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HAMPSTEAD JOLNEN CREST HASISTED LIVING CARROLL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Director 212 14 7660 Yrs AUG MARYLAND Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 la marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at HAMPSTEAN Directo CARROLL 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code BOX 2107 SA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: WHITE 3€Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) HAY & STRAW BROKER FARMING 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental EMORY C. LEISTER MAUNE 2 RHOTEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health at
important: if item 27 la. WILMINGTON NC 28405 1838 GLENCAGLESLANE H. Jack Leister 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) HAMPSTEAD CEM. 12/05/2006 HAMPSTEAD, MO 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JN ZUMBWN FH & MONGO 6028 SYKESVILLE ROOM ELDERS BURG-MD 21784 23a. Pen1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) 20mm /Medical Examiner Sequentially list conditions, 13 y 132 mg to inmodiat cause. Enter Underlying Cause (Disease or injury that initiated events Examine the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. I 1 Yes 2 No 9 Unknown 9 Unknown à signed t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed? Division of Vital 2 40 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check onl one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ho 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide hours after 24 hours a 1 Derrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 10 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 688 Poo. 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2006

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Ë	Pages ient of nt: if i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☒ Donation 5 ☐ Other (Specify)	emoval from State	сеп	netery, cřem	atory or oth	ner place	"		1					
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Baltin	permit. Pag Department Important: I eny Injury o once.		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	Cur	22.1 Va. 516	Name and Address	s of Facility reene Fu. Nooth P.	labole (neral Sv ke. Palt	ic Chore	MD	21229
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DIVIS	ital or Atten irs after deal ral Director: lled in by the	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify)		•		28f. Location (Si City or Town	n, State)		
	To the Hospital or Att. within 24 hours after de To the Funeral Direct. completely filled in by t	Medicai	29a. Certifier (Check only one) 1 Certifying Ph 2 Medicaf Exan 29b. \$ignature and title of certifier	ysician: To the best of my knowledger: On the basis of examination and manner stated.	edge, death on and/or inve	stigation, in my opi	inion, death occur	red at the time, d	ause(s) and ma ate and place, 9d. Date signe	and due to	the cause(s)
	7 3 5 8		Jacolpul.	completed rause of death (item 2	3a) (Tuna P		056419 Rando		, -		
0			Jocelyn 81-Sa	ayad 9109 L	iberte	Road	Rand	allstow	n, M	Da	1133
	Sta Registi		31. Date filed (Month, Day, Year) DEC 0 4	32. Registrar's Signatur	the An	ويثيده					

BALTIMORE 12. April 10. A				1 - State Amend Item 2	State of Ma 3a per dr	ryland / Depa ., G862, L2/ 	otment 04/06 tificate	of Health and of Death	d Mental Hyg	giene () (38400
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Director Part				Valencia La	Tra-1				11	21 20	06 8:00 PM
Social personnel Social pers		Examir	ner		street and/number)		4b. City, To	wn, or Location of De	path	4c. County of [Death
219-30-4257 LONSDAIR_FLAT 100 Courty 100											
Description of Description Description			Н							, Year) 9.	Birthplace (State or Foreign Country)
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The control of the variety of the control of the co		land				10c. City, Town or Lo	cation				10d. Inside City Limits
The control of the variety of the control of the co		Man He	to	MD		RAT.TTMOE) Er				1 Yes 2 No
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Description Part Description Descrip		9 E M =		BESSIE LEE KIM-	NIECE						
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Physician Medical Examinor Ph	Ë	Page nent c nt: # iry or			emoval from State	EVANS FU	NERAL	HOME 11/	24/2006	FOREST	HTT.T. MD
Physician Medical Examinor Ph	<u>=</u>			21. Signature of Funeral Service License	99	1 22	Name and A	ddress of Facility			HILDE, NO
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Physician Medical Examiner Texaminer Texam				23a. Part1. Enter the disease, or compli	cations that caused	the death. Do not ente	or the mode of	dying, such as card	ac or respiratory arr	est,	Approximate
Due to (or as a consequence of): Description Descript		Physician		Immediate Cause (Final		1 . 0	MVSr	r Gardin	1. Arrest		Onset and Death
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That it is the control of the contro	Е	Exammer	_	Sequentially list conditions,							10 years
That it is the control of the contro		ed isit	ine	if any, leading to immediate cause. Enter Underlying			A 1. 1.				
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29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 33 3 3 3 N. G. Neer f. St. #GCO Bacoo Month Bacoo And due to the cause(s) and manner as stated. 39a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 33 3 3 3 N. G. Neer f. St. #GCO Bacoo Month Bacoo	ב		ő		28a. Date of Injury (Month, Day		28c.	Injury at Work?	28d. Describe ho	w injury occurred	
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30. Naver and address of person who completed cause of death (Item 23a) (Type, Print) 33333 N. GIVERT St. #660 Bacro no 21218		vithin To the	Me	29b. Signatore and title of certifier			29c. Lie	ense number	2	9d. Date signed (Mo	onth, Day, Year)
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3333 N. Calvert St. #660 BacTO mo 21218			+	30. Name and address of person who con	mpleted cause of de		Print)			11/2/	100
1 Date filed (Month Day Very) 22 Serieted Single				3333 N.	11101			BOICID	mo	21218	
State of Dec 0 4 2006 32 Registrar's Signature			_	S1. Date filed (Month, Day, Year)	32 Registrar	's Signature	enter?				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 0 0 6 Registrar Amend item#18, perFH, G862, 12/4/06 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2:30 AM **Physician** ENA MILOSEK 10 V 29 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hours Min. 8. Date of Birth (Month, Day. A 506 57 6RUND 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F Months 93 Yrs. Director 213-05.5439 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. Count 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-1 show other treumatic event, the Madical Experiment must be notified at Yes 2 □ No Directo ALTIMORE 10g. Citizen of What Country? 10e. Street and Number 806 21224 57 1.5. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Coffege (1-4or 5+) Efementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) I and Mental OHN MICHOLAS HABERKAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) f Health Date 20a. Method of Disposition 20c. Location - City or Town, State ₹ <u>=</u> 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department of Important: If eny injury or once. LHWN CLEM 22. Name and Address of Facility

1149-76114 VKC

700 5 CONKLING 21. Signature of Funeral Service Licenses 700 BALTO 57 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. proximate Interval Between Onset and Death Immediate Cause (Final **Physician** portensive otheroscientic cardio vascular disesse disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ending physician and or use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete hes t autopsy perform rmed? 200 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? 1 ¼ Yes 2 ☐ No Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Scene To the Hospital or Attending Phys within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral dir this 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) Toller mo O.C. M. E 13-01-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARONILA III Pain Street BALTIMORE HD

State Registrar 31. Date filed (Month, Day, Year)

DEC 0 4 2006



South

State of Maryland / Department of Health and Mental Hygien 2 0 0 5 38402 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 27, Physician Miskimon Clara Margaret 2006 10:55A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dundalk Baltimore 1205 Willow Road If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 1 □ F 83 Yrs. 216-12-6159 CA Director 14,1923 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow rthan "natural", or itema 23a or 28a-f ahoi tra Medical Exeminar must be notified at Dundalk 1 ☐ Yes 2 XNo Baltimore Directo Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21222 United States death v 1205 Willow Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ Specify 3 ⊠ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than Own Home permit. Pages 1 and 2 should be flied v
Department of Heelth and Mental Hygier
Important: If Item 27 is marked other tt
any injury or other traumatic avent, IIIa
DDCE. Homemaker 6. Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beatrice Destol Arjen Kuiken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Hines (Daughter) 1205 Willow Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ☐ □ Donation 5 □ Other (Specify) 12/2/2006 Baltimore, Maryland Oak Lawn Cemetery 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Ave. Dundalk, Maryland 21. Simplure of Funeral Service Licery ee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition **Physician** 0 resulting in death) /Medical Due to (or as a consequence of) Examiner Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1 Yes 2 No 1 ☐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 1 Yes 2 Certification: To 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending il Diractor: A 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 100 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of pe who completed cause of death (Item 23a) (Type, Print) 4990 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1 2006 Month **Physician** Catherine Rose MacFetrich 10:20F M NOVEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 213-28-2029 1 □ M 2 🔀 F 77 09-27-1929 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Mary land N/A Director Baltimore 1 ☐ Yes 2 👿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 4616 Elsrode Avenue 21214 U.S.A. Funeral ural", or items ? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: Completed by 3 XWidowed 4 ☐ Divorced White 1 and 2 should be filed within 72 hc Health and Mental Hygiene. em 27 Is marked other than "natui other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Drug Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Buckheit Anna McIntvre ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 27 ls and injury or other trau James W. MacFetrich - Son 1205 Meadow View Road Pasadena, Maryland 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer Cemetery 12-04-2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signatur Funeral Service Licens 22. Name and Address of Facility 5305 Harford Road Hord Leonard J. Ruck, Inc. Baltimore, Maryland 21214 11 men 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physlcian: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont 1 Yes 2 No 9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 autopsy perform Yes 2 certificate l Yes director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Tyes 2 No Certification: To 1 ☐ Inpatient After this funeral Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No thours after death. 2/ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide hin 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certif 29c. License number D46356 Vovember 30,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHOSROW TARASSI D 7601 OSLER DRIVE TOWSON, MARYLAND 21204 324Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 4 Registrar

			For	State of Marylan	nd / Department of F		lental Hygier	ne 2006	38404
			- State Registrar		Certificate of	Death	Reg.	N6. U U U	3. Time of Death
Ph	ysicia	an	Decedent's Name (First, Middle, Last)	\circ	MASON			Day Year	9:4514M
	Medic		4a. Facility Name (If not institution, give	street and number)		or Location of Death	11 7	4c. County of Death	
EX	amin	er	9966 OAKLES			COTT C	ity	Howa	N
Fun	eral		5. Social Security Number 6. Sec	7. Age (In yrs.		If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye.	9. Birthi	place (State or Foreign
Dire			175-20-6625	M 250F 9.	Yrs. World's Days	Trouis Ivial.			Jersey
Pu A			Usuel Residence of Decedent 10a. State 10b. County	10c. Cir	ity, Town or Location				10d. Inside City Limits
faryla sho	N D	ö	. 1	_	BALTIMOVE				1 AYes 2 □ No
of Z. 1. 2. 1. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.	idical Examiner must be notified at	Funeral Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	ntry?
with 3a or	4	<u> </u>	815 N. WOO.	oring to	RD 21	2.29		LASV	<u> </u>
death me 2	E E	Jera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was Decedent of H	Hispanic Origin? (Special, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri Black, White,	
efter o	ä		1 Never Married 2 Married	1 Yes 2 No	1 ☐ Yes 2X No		rican, etc.)	Canaifu	
nours uraf.	Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			1	Rc	sac lc
72 1	dica	Completed	15. Decedent's Edu (Specify only highest grad		16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of worki	ng 16b	. Kind of Business/In	dustry
withir Bne.	1	μū	Elementary/Secondary (0-12)	College (1-4or 5+)	11	Keeper	'	Privat	e
Hygie C	aut, II		17. Father's Name (First, Middle, Last)		House		(First, Middle, Maid		
y rail of 1.6 build be filed with Mental Hygiene.	ic • v	То Ве	Elmer 1	Villiams	501	Ber	this G	evouev	•
should Ind Men	unat	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing Address (Street	and Number or Rura			
and 2 and 2 balth a	er tre		CAROL Chis	John	815 N- WO	t prijago	un BAC	am or	21229
of He	to the		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ F		Place of Disposition (Name of cemetery, crematory or other pla	ice)	Date 20c	. Location - City or To	own, State
Peges ment of	ury o		4 Donation 5 Other (Specify)	E.	wing Cemeter	ry 11-2	4-00	Trenton	W.5,
permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 Is marked other then.	eny in		21. Signature of Funeral Service Licens		22. Name and Addre) \.	
407	ĕ a		Ungha C	aveeve	SIST B	. 401	nath f	IVE Z	1229
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	re cause of each line.	th. Do not enter the mode of dyl	ing, such as cardiac d	or respiratory arrest,	TIA	Approximate Interval Between Onset and Death
Physi- /Med			Immediate Cause (Final disease or condition resulting in death)	HDV	MNCEL) DE	MEN	1117	
Exam				Due to (or as a consec	quence of):				
		e	if any, leading to immediate	Due to (or as a consec	quence of):				
uted	ansit	Examin	Cause (Disease or injury						
be executed icien and	rial-tr	Exa	resulting in death) Last	Due to (or as a consec	quence of):				
ite be	the burial-transit	dicai	(d					
raffica Po P	as II		IF FEMALE:						
Ith ce	or use	an/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta		су		23d. Date of deliv	ery Day Year
the a	hed fo	Physician/Me	1 Yes 2 XNo	4☐Pregnant at time of c 9☐ Unknown	death 5 Other (specify)				54,
The law requires thet the death certificate site has been signed by the attending phys	should be detached for use as i		Part II. Other significant conditions co.	ntributing to death but not res	sulting in the underlying cause or	ven in Part I.	23e. Did tobacc	co use contribute to t	the cause of death?
quires n	d be	d by					1 ☐ Yes	2 127No 3 □ Prol	bably 4 Unknown
	shou	Completed					24a. Was an	24b. Were auto	onsy findings available
he lay	99 2	μ					autopsy performed	? death?	opsy findings available ompletion of cause of
In: T	or, pa	ပိ	25. Was case referred to medical			26 Place of Death	1 ☐ Yes 2X h (Check only one)	No 1 ☐ Yes	2 No
reicie	direct	0 0	examiner?	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA Ot	h		6 Sother (Specia	MISSTLIVI
2 E E	ıeral	T;	27. Manper of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Inju		28d. Describe how in		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ath.	e fur	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day 10a)		Yes 2 No			
i or Atte	J in by ti	ertification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factory, office ify)		28f. Location (Street City or Town, St	t and Number or Run tate)	al Route Number,
DIVISION O'LIGHT TO THE HOSPITED TO THE HAW WITHIN EA HOURS after deadth. To the Funeral Director. After this certificate hes	tely filled	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowner: On the basis of examinating and manner stated.	owledge, death occurred at the tation and/or investigation, in my	ime, date and place, opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as s and place, and due t	itated. o the cause(s)
o the	ошрів	Med	29b. Signature and title of certifier	and married stated.	29c. Licen	se number	29d.	Date signed (Month)	(Day, Year)
- 3 -	ัช		> Jevne	Thea	De	0631	42	11/21/	06
3			30, Name and address of person who co	Impleted cause of death (Iter	m 23a) (Type, Print)	EN BUI	RNIE	KOESL	GR RD

State Registrar

31. Date filed (Month, Day, Year)

ORIGINAL.

State of Maryland / Department of Health and Mental Hygiene 06 38405 1- State Amend #8 Per FH G862 12/05/06 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Loretta Matson November 30 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harbor Hospital Baltimore 8. Date of Birth 04-1931 Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 133-24-7201 Director 5/04/1931 NY Usual Residence of Decedent death with the Maryland ehow. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23a or 28s-f ehov with injury or other treumatic event, the Madical Examinar must be notified at once. Be Completed by Funeral Director 1∰Yes 2□No MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2600 Wegworth Lane 21225 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1☐ Yes 2☑ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Colen Ruth Colen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Matson / Son 141 Whitney Place, Cheektowaga, NY 14227 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 12/03/2006 Catonsville, MD 21. Signature of Funeral Service Licensee Gary L. Kaufman Funeral Home at MMP, INC. M01378 7250 Washington Blvd., Elkridge, MD 21075 23a Part. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIAC DYSZHYTHMIA in nelinte /Medical Due to (or as a consequence of) Examiner CONONDAY ANTERY DISEASE reary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Yen Contive least sauce and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Year! Physician/Medical Dia Betel LLITI IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant al time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1□ Yes 22 No 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 - ER/Outpatient Certification: To 1 Inpatient 3□ DOA this s after death.

I Diractor: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled within 24 hours a To the Funeral C 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D0061439 30 2006 ddress of person who completed cause of death (Item 23a) (Type, Print) HNDREW 11KOVITZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006 dagalla)

State of Maryland / Department of Health and Mental Hygiene 38406 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Morkost ovember 26, 2006 Intonia 12300m /Medical City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Examiner Limore romule Baltimore If Under 24 Hrs. 7 Age (In yrs. lest birthday) If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1 ☐ M 2 ☑ F Director Maryland 1940 212-40-5950 Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Marylend nent of Heatth and Mental Hygiene. and to them 27 is marked other than "natural", or frems 23s or 28s-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo **Funeral Director** Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21220 **USA** 305 Holly Drive 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Be Completed by 3 Widowed 4 Divorced Year or Detes: White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Toll Collector State Government 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Emily Frances Chyojan Bohus Joseph Morkosky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) James A. Morkosky / Brother 25 Burr Hill Dr., Ocean Pines, MD 21811 Injury or other 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Buriel 2 Cremetion 3 Removal from State Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 11-29-06 Baltimore, Maryland Most Holy Redeemer Cem. 22. Name and Address of Fecility
McComas Funeral Home, P.A. 21. Signa ure Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complic shock, or heart failure. List only or nons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset end Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence Be Completed by Physiclan/Medical Examiner eral Director: After this certificate has been signed by the attending physician and filled in by the funerel director, pege 2 should be detached for usa as the burial-transit or Attending Physician: The lew requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 DNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 210No 1 ☐ Yes 2 ☐ No T Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Junursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by tha fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and manner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. (Check only one) 29b. Signature end title of certifie 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 8710 Emgl 31. Date fligd (Month, Day, Year) 32 Registrer's Signature Registrar 0 4

DHMH 16 Rev 6/95

State

0

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

Registrar
DHMH 17 Rev 1/2001

MU

32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nimesh Shah, M.D.

31. Date filed (Month, Day, Year)

DEC 0 4

64415

9901 Medical Center Drive, Rockville, Maryland 20850

November 28, 2006

			For State Registrar	State of Maryland	-	rtment of H			giene	38408
	4.1		Decedent's Name (First, Middle, Last	st)				2. Date of Dea	ath	3. Time of Death
П	Physici		John E. Manson					Nov 29	, 2006 Ye	2:20p M
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of		4c. County of D	
	. E AGIIII		135 Bayside Dr	ive		Edgeme	re		Baltin	nore Co.
	Funeral		Social Security Number 6. S		t birthday)	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of Birth Min. (Month, Day		Birthplace (State or Foreign Country)
	Director		220-20-6174	X M 2□F 78	Yrs.	Months	riours	June 1	4,1928 M	laryland
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation				10d. Inside City Limits
	ehow	5	,							1 Yes 2/3/No
	Ne M	ectc	MD Baltim 10e. Street and Number	ore, Co. Edg	emer				10g. Citizen of What	
	a or	Funeral Director	135 Bayside Dr	ivo		10f. Zip Code 2122	2		USA	
	eath	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. V			in? (Specify Yes or No-		American Indian,
	tter d	표	1 ☐ Never Married Ž∭Married	Armed Forces? 1 ☐ Yes 2 🔀 No	li li	Yes, specify Cuba	n, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)		Vhite, etc.
936	urs a	þ	3 Widowed 4 Divorced	It Yes, Give Year or Dates:	1	Yes 2X No	Specify:		Specify: W	Mhite
21215-0036	within 72 hours after death with the Maryland ene. han "naturel", or Items 23a or 28a-f ehow he Medical Exeminat must ke nutifiest at	Completed	15. Decedent's Éc (Specify only highest gra	ducation	16a. Deced	lent's Usual Occupa	ation	of working	16b. Kind of Busine	ess/Industry
21	thin 7	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)	or working		
CA	ed wi	Sol	11		Bric	klayer			Constru	ction
nd	nould be filed within a Mental Hygiene. narked other than natic event, the M	Be	17. Father's Name (First, Middle, Last)					's Name (First, Middle,	Maiden Sumame)	
yla	should ind Men marke umatic	은	James Henry Mar					l White		
Maryland	2 st and ts n		19a. Informant's Name/Relationship (in the		or Rural Route Numbe		
a)	and tealth om 27 ther to		Martha Manson - 20a. Method of Disposition		135	Bayside	Driv	re Edgetni Date	ere, MD	21222
Baltimore,	permit. Pages 'Department of H Important: if Ite any Injury or of		1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	netery, cren	natory or other plac	(9)			
ţ	t. Pa rtmen rtant:		4 Donation 5 Other (Specif			Cremato			Baltimor	e, MD al Home, PA
Bal	Deparenti Deparenti Impo any Ir		21. Signature of Funeral Service Licer	1800	1 2	Name and Addres	ss of Facility	Venue R	altimore	al Home, PA , MD 21222
	40380	\vdash	Male de la company de la compa	aliantians that assumed the death						Approximate
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	Do not ent	ar the mode of dyini	g, such as c	ardiac or respiratory ar	rest,	Interval Between Onset and Death
120	Physician		Immediate Cause (Final disease or condition resulting in death)	a Lung Car	ncer					
	/Medical Examiner		1 Suiting in douting	Due to (or as a conseque	nce of):					
18		_	Sequentially list conditions,	b	nce of):					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
	al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as a conseque	nce of):					
760,	The law requires that the death certiticate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	calE		d						
687	ticate p phy-			, u,						
Вох	nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance					23d. Date of	delivery
m	that the death cert ed by the attendin detached for use	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal di 4 ☐ Pregnant at time of dea		Ectopic pregnancy Other (s <i>pecify</i>)			Month	Day Year
P.0	t the by the ache	hys	9 Unknown	9□ Unknown						
	s tha	by P	Part II. Other significant conditions of	contributing to death but not resulti	ing in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contribut	e to the cause of death?
ğ	quires f	pa				<u></u>		1 🗆 Y	′es 2 □ No 3 □	Probably 4X Unknown
Records,	s been si 2 should	piet						24a. Was	an 24b. Were	autopsy findings available to completion of cause of
æ	The It	Completed						autop perfor 1 □XYes	rmed? deat	to completion of cause of h? Yes 2 XNo
Vital	an: rtifica	0	25. Was case referred to medical	183			26. Place	of Death (Check only o		.oo can
\leq	Physician: this certific ral director,	To B	examiner? 1 □ Yes 2 🖔 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	NOutpatien	t 3 DOA Othe	er: 4 🗆 Nur	sing Home 5 ☑ Resid	lence 6 Other (5	Specify)
J of			27. Manner of Death 1 ☒Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work			now injury occurred	
Division	Attending r death.	Certification:	2 Accident investigation	n	,,		Yes 2□N	0		
ĕ	lor Attendate after death Director:	tific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		e, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Number o	r Rural Route Number,
0	rs after of Direction to the control of the control									
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely tilled in by the	Medical	(Check only 2 Medical Exam	nysician: To the best of my knowle miner: On the basis of examinatio	edge, death n and/or inv	occurred at the time vestigation, in my or	ne, date and pinion, deat	place, and due to the on occurred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	the hin 2 the the the the the the the the the the	Med	one)	and manner stated.		29c. License				
	To To cor		29b. Signature and title of certifier	ell MD			- 000		29d. Date signed (M	1, 2004
	d		the state of	,					December	1/2001
8			30. Name and address of person who Dr. Jeffrey Hi	completed cause of death (Item 2 $\operatorname{ghfill}_{M}.D.$ 4	01.0	T t	Ave	Baltimon	re. Md	21224
U	1	10	31. Date filed (Month. Dav. Year)	32/Registrar's Signatur	(b) 1830	Lastern		Dareimo	, 110 .	
7	Sta Regist		31. Date filed (Month, Day, Year)	2006	1					

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

9. Birthplace (State or Foreign 1934 Mary Land

9:23 PM

10d. Inside City Limits 1 Yes 2 No

	Physici /Medic		Nola Cor	nchita M	itchell							Novemb	per 29,	2 00 6	9,23
	Examin		4a. Facility Name (ABALTIMO)	-	nive street and nui ngton Ho			4b. City		Location Glen		ie		nty of Deat	
	Funeral Director		5. Social Security N 213-32-9		Sex 1 M 2 KF	7. Age (In yr:	s. last birtho		r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth Ay, Year 1934	9. Birt Mary	hplace (State or For unitry) /Iand
	P >		Usual Residence of			10.0									
	aryta shov	-	10a. State	10b. County			City, Town o								10d. Inside City Lin
	Ne M	ecto	MD		rundel	Al	nnapo:								1 ☐ Yes 2 █
,	th with t 23a or 2 sat be n	al Dir	570 Bell		cive				409				10g. Citizen d United		,
7 2 3 9 8	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or iteme 23a or 28a-f show any injury or other treumatic event, the Madical Examinat must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Marr 3 Widowed	ied 2 Marned	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Gin Year or D	rces? 2 No /e	U.S.	13. Was Dece If Yes, spe 1 ☐ Yes		ispanic Or in, Mexica Specify:		ecify Yes or N Rican, etc.)		ace - Ame lack, White	ncan Indian, e, etc.
? 을	2 hou	edt		15. Decedent's		a185.	16a. D	ecedent's Usu	al Occup	ation			16b. Kind of		Industry.
1215	within 73 ene. then "na	mplet	(Spec	cify only highest g		-4or 5+)	- (6	live kind of wo te. DO NOT u	ork done d se retired	during mos	t of work	ing	Domes	tic	noustry
エこいと / / / の Maryland 21215-0036	ld be filed ental Hygi ked other ic event, II	To Be Co	17. Father's Name	(First, Middle, La Johnson	•					18. Moth		<i>(First, Middle</i>	e, Maiden Sum	ame)	
	nd 2 shou alth and M 27 is mar r treumati		19a. Informant's Na Marvin M				19b. M	ailing Address	s (Street a	and Number	er or Rura	Al Route Numb	per, City or Tow Ville,	n, State, Z	ïp Code) L 108
I Baltimore,	Pages 1 a nent of Hea nt: If Item ry or othe				☐Removal from :	State	cemetery,	sposition (Na. crematory or o	other plac			Dec 5 2006	20c. Location		
Balti	permit. Departm Importa eny inju		21. Signature of Fu			At		22 Name a 1922	d Address Fore	Metali est D	Spol:	itan Ch Annar	napel polis, N	4D	
9	Physician /Medical Examiner		23a. Part1. Enterth shock, or hea Immediate Cause (disease or condition resulting in death)	rt fallure. List on: (Final	a. Met	ach line.	atic	enter the mod		1	cardiac o		arrest,		Approximate Interval Between Onset and Death
760,		cal Examiner	Sequentially list confirmation if any, leading to imcause. Enter Unde Cause (Disease or that initiated events resulting in death) L		с	or as a conse									
.O. Box 68760,	Q 0 Q	nysician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		irth 2∏Fet ant at time of	tal death	3 ⊟Ectopic pi 5 ⊡ Other (sp					1	eate of deliving	very Day Year
rds, P	w requires that the been signed by the should be detache	ed by Phy	Part II. Other signif	icant conditions	contributing to de	ath but not re	sulting in th	e underlying o	ause give	n in Part I			obacco use co	ntribute to	the cause of death?
Division of Vital Records,	The law ete hes b page 2 st	Completed	25 Wo								_	24a. Was auto perfo	an 24b psy primed 2 No	. Were autoprior to codeath?	opsy findings availa ompletion of cause of
<u> </u>	sicien: certifice irector, p	Be	25. Was case referrexaminer?		Hospital:	/	7.00.		Othe	_		(Check only o			
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ision	Attending in death. actor: After by the funer	Certification:	1 ☑Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending investigate 6 ☐ Could not	be 200 Bloom	of Injury h, Day Year) of Injury - At h	Injur	М		at ? ′es 2 □ l	No				- 1 D 1
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	To the Hospital or within 24 hours after to To the Funeral Director completely filled in	Medical	one)	Z Medical Exa	hysician: To the miner: On the ba and mann	er stated.	ation and/or	investigation	, in my op	inion, deal	h occurre	and due to the ed at the time,	cause(s) and m date and place	nanner as s , and due t	itated. o the cause(s)
	To To con	₹	29b. Signature and	title of certifier	E. W.	ilys	MI	D 290	De	number 1365	5		29d. Date sign		Day, Year) 2000

Jovenber 29, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Glen Burnie, MD 21061

3 ☐ Probabiy 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Registrar

State

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** rar KS 30 Ear 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) University
5. Social Security Number 1aryland Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F 178-26-85 73 Usual Residence of Decedent Pennsylvania Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Director Suffolk New York Babylon 10f, Zip Code 10g, Citizen of What Country? 10e. Street and Number 11757 United States 22 E. Beach Promenade Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1953 -14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or items 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No White If Yes, Give Year or Dates: 3 ☐ Widowed 4 X Divorced 1955 Be Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Mechanic Supervisor Airlines or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) It of Health and Mental William E. Parks Garnet McAllister ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Diane Murgittroyd, Sister 294 W. 24th Street, Deer Park, NY 11729 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or Calverton Nat'l Cem. 12/05/2006 Calverton, New York 4 ☐ Donation 5 ☐ Qther (Specify) M01113 21. Signature of Funera 22. Name and Address of Facility Bay Shore Funeral Home Service Ligensee 42 Second Avenue, Bay Shore, NY 11706 Approximate Interval Between Onset and Death 23a. Part1. Enter the release, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart reliure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner brain Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine cardiac arres Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria entricular tachycardia by Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cardiomyopathy 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide n 24 hours after ne Funeral Dire pletely filled in b 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AU4176435H-17422 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Bethel S.
32 Segistrar's Signature 57.

Registrar DHMH 17 Rev 1/2001

State

April Horton

DEC

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Baltimore, MD 21237

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 38411 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 18, Joe W. Patterson 2006 12:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2505 Welsh Avenue Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 X M 2 □ F Yrs. Director 566-36-7086 Jan 13, 1925 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Itam 27 is marked other than "natural", or Itams 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Directo MD 1√2 Yes 2 □ No Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2505 Welsh Avenue 21219 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after Armed Folces:
1 ∑Yes 2 □ No
If Yes, Give
Year or Dates: 142-46 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if Itam 27 Is markad other than Elementary/Secondary (0-12) College (1-4or 5+) unk unk boatman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joab W. Patterson Venetta Lee Shiflett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Patterson/spouse 2505 Welsh Avenue Baltimore, MD 21219 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if Ita any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature Seuneral Service Licensee Ronald S. Wade State Anatomy Board Baltimore, MD 21201 Director 655 W. Baltimore Street Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or nearl failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Sone Physician marrow cars resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) P.0. ed by the 9□ Unknown 9 Unknown The law requires that signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>۾</u> cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 1 No Be 25. Was case referred to medical director 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending death. М investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 🗀 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ţ 29b. Signature and title of certifier 29c. License number 1041614 ww 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4920 c Usus Han Cayabell 31. Date filed (Month, Day, Year) 32 Registrar's Signat State DEC 0 4 Registrar 2006

			1- State of Maryland / Department of Certificate of	Dooth	ene 2006 38413
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year , " -> D
	/Medic		EMMETTE C. FETWAY	NOV	30 2006 6:35PM
j.	Examin	er	0: 0:	or Location of Death	4c. County of Death
	Funeval		5 Social Security Number 6. Sex / 7. Age (In yrs. last birthday) If Under 1 Yes	If Under 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		238-86-9400 10M 20F 55 Yrs. Months Day	s Hours Min. (Month, Day,)	Year) Country)
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	deeth	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of If Yes, specify Co	Hispanic Origin? (Specify Yes or No- ban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
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Maryland	d 2 sho h and 7 Is mu			et and Number or Rural Route Number, NETT PLACE BA	t (to, MD, 21223
	s 1 and 2 should be filed within 72 hours after deeth with the Marylan if Haith and Mantai Hygiene. Item 27 is marked other then "natural", or iteme 23a or 28e-f ehow other traumatic event, the Medical Examinar must be notified at	l	200. Nother of Disposition (Name of	Date 2	Oc. Location - City or Town, State
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Baltimore,	그는 근 글				
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io	Attending I r death. ector: After by the funer	atio	1 Natural 5 Pending (Month, Day 16a) Illuly 1 Accident investigation M 1	□Yes 2□No	
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,	2 8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	RATE NOAD	DEC 1, 2006
0		a to	31. Date filed (Month, Day, Year) 32. Segistrar's Signature	> INCHINALES	, in y will
	Regist	ate rar	DEC 0 4 0000 St.		

	S. Social Security Number 334-24-1667 July Land Residence of Decedent 10a. State 10b. County MD Prince Geore 10e. Street and Number 9003 East Bourne Lane 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade)	street and number) 7. Age (In yr 10c. (ges	Yrs City, Town o	Months Day 10f. Zip Code	rs Hours Min.	8. Date of Bin (Month, Da		10d. Inside City 1 Yes	
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Donald III	15. Decedent's Educ (Specify only highest grade	Year or Dates:		If Yes, specify C		o Hican, etc.)			
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	Aurin Minott Ripley					Compton			
	19a. Informant's Name/Relationship (Ty) Marie Ripley/Wife	pe, Print)						Zip Code)	
1			. Place of D	isposition (Name of crematory or other i	place)	Date	20c. Location - City o	r Town, State	
	1 ☐ Burial 2 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)					/2006	Catonsville,	MD	
	21. Signature of Funeral Service License	ee //		22. Name and Ad	dress of Facility				
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Be	29b. Signature and title of certifier	. 0		29c. Lic	ense number		29d. Date signed (Mor	nth, Day, Year)	
	1 5×1516	l ma		D	0057177		Nov 24	, 200	6
	30. Name and address of person who co	ompleted cause of death (,		Tolombia.	19112	21644)	
Cyaninica		19a. Informant's Name/Relationship (Ty Marie Ripley/Wife) 20a. Method of Disposition 1	19a. Informant's Name/Relationship (Type, Print) Marie Ripley/Wife 20a. Method of Disposition 1	19a. Informant's Name/Relationship (Type, Print) 19b. Marie Ripley/Wife 900.	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str 9003 East Bourn 9004 East Bourn 9003 East Bourn 9004 East Bourn 9003 East Bourn	19a. Informant's Name/Relationship (Type, Print) Marie Ripley/Wife 20a. Method of Disposition 1	19a. Informant's Name-Relationship (Type, Print) Marie Ripley/Nife 20a. Method of Disposition 1	19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Martie Ripley/Wife 9003 East Bourne Lane, Laurel, MD 20708	Sequentially list conditions Part Boule for significant conditions contributing to death but not resulting in the underlying cause given in Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part Pa

			1- State of Maryland		artment o			nd M		gien	4 U U	6	38415
	Physici	an	Decedent's Name (First, Middle, Last)			-			2. Date of De Month	Da	ıy	Year	3. Time of Death
B	/Medic		Louis Rowe		# 0' T	1			Decembe		, 200		8:20 A M
1.	Examir	er	4a. Facility Name (If not institution, give street and number) 5117 Lupine Court		4b. City, To			Death			County o		
**	Funeral	4	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1	Year	If Under 2		8. Date of Bir	th	ontgo	9. Birth	place (State or Foreign
	Director		151-16-6566 ^{1⊠M 2□F} 78	Yrs.	Months E	Days	Hours	Min.	(Month, Da May 22,	19, rear	28	Scot	tland
	p .		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Lo	cation							1	IOd. Inside City Limits
	shoved at	ā		ckvil									1 ☐ Yes 2 € No
	the N	rect	10e, Street and Number		10f. Zip C	ode				10g. Ci	tizen of W	hat Cou	ntry?
	3a or	Ö	5117 Lupine Court		208					Uni	ted S	tate	28
336	d within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23a or 28a-f show Ite Medical Exaulter must be multiled at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Deceder f Yes, specify		panic Orig Mexican Specify:	jin? (Spe , Puerto	ecify Yes or No Rican, etc.)	D-		, White,	can Indian, etc. iite
9	2 hou	ted		6a. Deced	dent's Usual (Occupati	ion	of worki	na.	16b. F	(ind of Bus	siness/In	dustry
21215-0036	within 7 ene. than "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. l	DO NOT use	retired)	mig most	Or WORK	ng				
121	e filed wi of Hygien other th		4	Bank	ing		O Mothor	ria Nama	(First, Middle	Maida	Fina		1
and	0 0 0	Be	17. Father's Name (First, Middle, Last) Alfred Rowe						lrymple		1 Sullianie	*/	
Maryland	s 1 and 2 should be t Health and Menta Item 27 is marked other traumatic es	2		19b. Mailir	na Address (S	Street an			I Route Numb		or Town, S	State, Zic	Code)
Ma	od 2 shoulth and 27 is my r traum								kville,				20853
ē,	is 1 and 2 of Health a ltem 27 ls		20a. Method of Disposition 20b. Place cem	e of Dispo	sition (Name	of er place	D	ecei	-				own, State
E			1₺ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Hung:	ars C	piscop	al Z	6	, 20	06	Bri	dgeto	wn,	Virginia
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee M00092	Ro	Name and CKV111	Address	of Facility Inc. Mary1	Rob 300 and	ert A. West M 20350	ont	ohrey Somer	y Av	eral Home enue
er.	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. If shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	vspla ce of):				cardiac c	or respiratory a	irrest,		2	Approximate Interval Between Onset and Death Years
68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last Due to (or as a consequen d	ce of):									
.O. Box	at the death certific by the attending p tached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3	Ectopic preg Other (spec						23d. Date Mon		əry Day Year
rds, P	w requires that been signed b should be deta	by	Part II, Other significant conditions contributing to death but not resulting	g in the ur	nderlying cau	se given	in Part I.			obacco Yes 2			ne cause of death?
Il Records,		Completed							24a. Was auto perfo 1 - Yes	psy ormed?	Di de	ere auto for to co eath?	psy findings available mpletion of cause of 2 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?			1	-		(Check only				
of		tion: To	27. Manner of Death 1 □ Inpatient 2 □ ER 28a. Date of Injury (Month, Day Year) 28a. Date of Injury (Month, Day Year)	Outpatien b. Time of Injury		Other	4 🗀 1401		me 51 Resi 28d. Describe				y)
Division	al or Attending s after death. It Director: After id in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, o				28f. Location (City or To			r or Aura	ul Roule Number,
	To the Hospital or within 24 hours after to the Funerel Dir completely filled in I	Medical C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and manner stated.										
)	To the comp	Σ	29b. Signature and title-of-centian)	į.	2153					nte signed ember		Day, Year) 2006
10)		30. Name and address of person who completed cause of death (Item 23 G Peter Pushkas, M.D. 11510 Old	Georg		Roa	d, Ro	ockv	ille, M	lary	land	2085	52
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Long	13.00								

State of Maryland / Department of Health and Mental Hygien 38416 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOV. 17, 2006 **Physician** DORIS JANE SOUDERS 3:45 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | A P R 25 , 1921 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 1 F MARYLAND 85 Yrs Director 214-16-1855 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, Ita Mudical Evaluational Evaluational any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. MONTGOMERY ROCKVILLE 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701- VEIRS DRIVE 20850 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) CLERICAL SALES OFFICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EDWIN STANLEY SOUDERS LILLIAN B. SOUDERS ပ 19a. Informant's Name/Relationship (Type, Print)
KRISTINA HUGHES— EXECUTOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9701- VEIRS DR., ROCKVILLE, MD. 20850 20a. Method of Disposition

Method of Disposition

□ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State REST HAVEN CEM. 11/21/2006 HAGERSTOWN, MD,. * 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ucensee 22. Name and Address of Facility
HYSONG CO., INC. PYSONG CO., INC.

23a. Part 1. Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. 2222- WISCONSIN AVE. N.W., WASH. DC Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician BNATERAL PNEUMONIA /Medical Due to (or as a consequence of). **Examiner** Due to (or as a consequence of): HLART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a onsequence of): attending physician a for use as the burial: Division of Vital Records, P.O. Box 68760 Physician/Medical d IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ☐ Yes 2 No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has autopsy 2-No 1 Yes or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Certification; To s after death.
I Director: After this id in by the funeral d 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 26f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide within 24 hours a To the Hospitei 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Where Sudling DO051158 NOULHBER 18 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HD 20850 AND THO WY ROCKVILLE 9701 VEIRS DRIVE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DEC 0 4 2006

			1 - For Amend #5, perF Registrar		20/06 TI C	ertificate of	Death	Le	g. 140.	38417
	Physici	an	Decedent's Name (First, Middle, L.					Date of Death Month	Day Year	3. Time of Death 4: 22 PM
	/Medic	al	COLLEEN E. S			th City Town o	r Location of Death	DECEMBER	4c. County of Deat	
	Examin	er	4a. Fecility Name (If not institution, gi			A A -			N/	
	Funeval		Johns Holkins BA 5. Social Security Number 6.		e (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	1	nplace (State or Foreign untry)
	Funeral Director		247 -13-2475	1□M 2[X F	35 Yrs.	Months Days	Hours Min.	AUG. 1	D,1971 MA	RYLAND
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. tnside City Limits
	a-f s	ctor	MD. N/A		BALTI	MORE				1 ☐XYes 2 ☐ No
	or 28	Oire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	ath w	rai	3426 BANK ST				1224		U.S.	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "naturel" or items 23a or 28s-f show or other treumstic event, it a Medical Examinat must be redified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S.	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No		ecity Yes or No- Rican, etc.)	14. Race - Ame Btack, White Specify: WH	
Ş	ture F	ed	15. Decedent's I		16a. Dec	cedent's Usual Occup	pation	1	6b. Kind of Business/	
21215-0036	nin 72 n "ne Medik	piet	(Specify only highest g.	rade completed) College (1-4or	life	ve kind of work done . DO NOT use retired	during most of worki d)	ing		
212	d with giene	E O	11	College (1 4c)		VAITRESS			RESTAURA	NT
	be filed ital Hygi d other event, I	Be	17. Father's Name (First, Middle, Las	(t)			18. Mother's Name	-		
yla	2 should be filed within 72 hours aft and Mental Hygiene. is marked other than "naturel", or eumatic event, the Medical Exami	2	CHARLES CARR				MARGAR		CHERT	
Maryland	2 sho		19a. Informant's Name/Relationship						City or Town, State, 2	
	l and lealth im 27		MARGARET CARRI	GAN/ MOTH		S. CONKI			TIMORE, M	
0	it of h		20a. Method of Disposition 1 Burial 2 Temation 3	☐Removat from State	cemetery, c	rematory or other place	ce)			
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tre once.		4 Donation 5 Other (Spec 21. Signature of Funeral Service Lice						BALTIMORE NERAL HOM	,MARYLAND
<u>m</u>	88 2 5 8		- Soula	2/3/1	nece !	700 S. C	ONKLING_	STREET,	BALTIMOR	E,MD. 212
			23a. Part1. Enter the disease, or con shock, or heart failure. List on	mplications that cause y one cause on each l	d the death. Do not a ine.	enter the mode of dyir	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition	a. PHEUM	OCYSTIS	PHEUMON	I'A			2 YAD P
	/Medical Examiner		resulting in death)	,	a consequence of):					
		b	Sequentially list conditions,	b. ACQUI	RED IMM	INE DEF	I C IENCY S	YNORUM	(E	
X	led nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		MMUN	ODE COLEAN	2V V (0 1)	t		
	xecul	xar	that initiated events resulting in death) Last		a consequence of):	3065 101634	CI VIKO	•		
68760,	ificate be executed g physicien and as the burial-transit	a	A	d						
687	:= C0 mi	edicai		-						
Box	attendin for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No		2 Fetal death	3 Ectopic pregnanc 5 Other (specify)	у		23d. Date of dei Month	ivery Day Year
P.O.	at the de	F.	9 Unknown Part II. Other significant conditions	anatabuting to death	but not regulting in th	underhies sauce su	von in Part I	23e Did toh	acco use contribute to	the cause of death?
	w requires that been signed b should be deta		Part II. Other significant conditions	contributing to death	but not resulting ar the	e underlying cause gr	veri in Paitti.			obably 4 Unknown
Division of Vital Records,	has b	Completed by						24a. Was an autops perform	v prior to	stopsy findings available completion of cause of
ta	ician: Th certificate ector, pag	BeC	25. Was case referred to medical				26. Place of Deat			74.0
<u>></u>	dis y	To B	examiner? 1 Tes 2 No	Hospital: 1 Inpat	ient 2 ER/Outpa	tient 3 DOA Ott	her: 4 Nursing Ho	me 5 Reside	nce 6 □Other (Spe	cify)
ō	ding Phys h. After this funeral di		27. Manner of Death 1 Matural 5 Pending	28a. Date of Inj (Month, D	ury ay Year) 28b. Time Injur		ry at	28d. Describe ho	w injury occurred	
<u>0</u>	ending eath. or: After he funer	catio	2 Accident investigat	bo]Yes 2□No			
Ξ̈́	or Att fler de lirect n by t	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	289. Place of in	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location (St.	reet and Number or Ri i, State)	ural Route Number,
Ω	urs el urs el prel D		17/2-14							
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fo	Medical		Physician: To the bes aminer: On the basis and manner s	of examination and/o					
	ithin ithin or the comple	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mont	h, Day, Year)
	F 3 F 8		29b. Signature and title of certifier	Thioudalhi	, M.D.	RES-	000	Ū	EGEMBER	1,2006
	\cap		30. Name and address of person wh	o completed cause of	death (Item 23a) (Ty	oe, Print)				
	<i>↑</i>		DR. NESTORAS 31. Date filed (Month, Day, Year)	MATH 1000	AKIS 41	43 EASTE	ern aven	INE RY	LTIMORE, N	1ARYLAND 217
	St Regist	ate rar	DEC 0 4 20	06	trar's Signature	sold !				

		ľ	1 - For Amend item#1,	perMD, go	362. 12/4/	/06 TC <i>el</i>	artment of H tificate of I	ieaith and D <i>eath</i>	Mental Hy	giene Reg. No2	006	38418
ľ	Physicia /Medic		1. Decedent's Name (First, Middle, BERNADETTE		lette Catl		canley		2. Date of De Month	Day	Year 2006	3. Time of Death 9:02 PM
	Examin		4a. Facility Name (If not institution, g				4b. City, Town, or		ıth	4c. Cou	inty of Death	
			JOHNS HOPKINS 5. Social Security Number 6	. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	IMORE	s. 8. Date of Bi	rth	9. Birth	N/A place (State or Foreign
	Funeral Director		220-94-3378	1□M 2 又 F	30	Yrs.	Months Days	Hours Min		ay, Yea <i>r)</i> .2 , 1 975	Cou	ntry) cyland
	n w		Usual Residence of Decedent 10a. State 10b. County		10c. Cir	ty, Town or Lo	cation					10d. Inside City Limits
	Maryla f sho	ō		timore		.,,			Dunda	ılk		1 ☐ Yes 2 ☑ No
	r 28a-	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	ntry?
	tth wit 23a o ust be		3002 Liberty P	arkway				21222			ed Sta	
	er dea items	Funeral	11. Marital Status	Armed F			Was Decedent of H f Yes, specify Cuba	ispanic Origin? (an, Mexican, Pue	Specify Yes or No erto Rican, etc.)		Race - Ameri Black, White,	
330	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	2 ☆ No iive Dates:		1□Yes 2XINo	Specify:		Spi	ecify:	White
2-00-c	72 hou natura Jiçal E	eted	15. Decedent's	Education grade completed)	16a. Deced	dent's Usual Occup	ation during most of w	orkina	16b. Kind o	f Business/Ir	ndustry
7	vithin the.	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)		kind of work done of NOT use retired	1)	9			
7	filed v Hygie other t	ပ္ပို	17. Father's Name (First, Middle, La	<u>l Year</u>	<u> </u>	Но	memaker	18. Mother's Na	ame (First, Middle	, Maiden Sur	Home name)	
/land	lid be fental rked o	To Be	David Elmer S					Daw	n Victor	ia Koc	h	
lary	2 shou and N is mai		19a. Informant's Name/Relationship	(Type. Print)			g Address (Street					,
e, ≅	l and lealth		Mrs. Dawn V. Ku	hnert (1	<u>·</u> _		2 Liberty	·	y Dunda Date			
	ages 1 int of 1: if ite		20a. Method of Disposition ↑		ı şiaie		sition (Name of matory or other place				on - City or T	
Saltimor	artme ortant Injury		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service		Ga	22	of Faith 2. Name and Addres	ss of Facility				Maryland
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ľ			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that	caused the dea							Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	a. ENT	D STAG	E REI	VAL DIS	EASE			1	Onset and Death 3 Years
	/Medical Examiner		resulting in death)		(or as a consec							a cooks
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28/00,	icate b physic the b	dical		d								
POX	w requires that the death certific been signed by the attending I should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome pf pregn	nancy	7e			23d.	Date of deliv	rery
Ď	death	sicia	in the past 12 months? 1 ☐ Yes 2 🗷 No		birth 2 ☐ Fet		Ectopic pregnancy Other (specify)				Month	Day Year
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Hecords,	v requ	Completed							24a. Was			opsy findings available
	The law ate has bo	duc		-					- I auto		prior to co death?	empletion of cause of
VII		ø	25. Was case referred to medical					26. Place of De	1 Yes eath (Check only		1 ☐ Yes	2 No
0 0	ding Physician:). After this certification funeral director,	To B	examiner? 1 ☐ Yes 2 No		<u> </u>] ER/Outpatier		4 🗆 Nursing	Home 5 ☐ Res	idence 6 🗆	Other (Speci	fy)
	ing P After t funera		27. Manner of Death 1. Natural 5 □ Pending	(Mo	e of Injury onth, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2∐No	28d. Describe	how injury oc	curred	
JIVISION	Attenc death cctor: y the	ficat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no determin	t be 28e. Plac	e of injury - At h	ome, farm, str	eet, factory, office	Tes ZINO	28f. Location	(Street and N	ımber or Rur	al Route Number,
2	al or / s after	Certification:	4 ☐ Homicide determin	buil	ding, etc. (Speci	ify)			Cify or To	wn, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical (29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	kaminer: On the	ne best of my kn basis of examin nner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my c	me, date and pla ppinion, death oc	ce, and due to the curred at the time	cause(s) and date and pla	manner as s ce, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	. 0 0	^	0.5	29c. Licens	e number			gned (Month,	
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	Sta	to.	JESSICA COLBURA 31. Date filed (Month, Day, Year)	I, MD J	HBMC Registrar's Sign	4940 E	ASTERN P	the B	MITIMOR	E 1100	2122	<u> </u>
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38419 State of Maryland / Department of Health and Mental Hygiene [] [] [5] For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vear **Physician** 1:08 PM M November 18, 2006 Marie Stewart /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Phoenix Baltimore 14309 Phoenix Road 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Hours 1 ☐ M 2 🖁 F Aug 17, New Jersey 81 149-14-4497 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County th and Mental Hygiene. 71s marked other than "natural", or items 23s or 28s-f show traumatic ayant, the Medical Examination at the notified at 1 ☐ Yes 2 ☑ No Director Phoenix Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code USA 21131 14309 Phoenix Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or iter any highry or other traumatic avant, the Medical Examination. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: white Baltimore, Maryland 21215-0036 ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) agriculture farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertram Foulkes DDS Maidie Schaeffer ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14309 Phoenix Road Phoenix, MD 21131 Perry Stewart/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriat 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street
Raltimore, MD 21201 21. Signature of Funeral Service Licensee Ronald S. Wade 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and 6 eath Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use es the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 9 Unknown this certificate has been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an COPL performed? 1 ☐ Yes 2 No 26. Place of Death (Check only one) within 24 hours efter death. To the Funeral Diractor: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 1 Natural
2 Accident Hospital or Attanding 5 Pending 1 TYes 2 No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier 29c. License number 1324053 Lamo 11-27-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD ent Velle Mark Lamas

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

DEC 0 4 2006

donate !

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

38420

Funeral

Physician

/Medical Examiner to the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit led by the attending physician and detached for use as the burial-tran Division of Vital Records, P.O. Box 68760, signed by peen : has certificate after death.

Director: After this certific within 24 hours a To the Funeral I

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year ulo 30 ernice Ś 2006 /Medical 4a. Facility Name (If not institution, 4b. City, Town, or Location, of Death County of Death Examiner SG Center HIMOK Days Hours Min Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Baltimore Randallstown 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4511 Robeson Road 21113 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 🎇 No Specify: Specify: black Completed by 3 ♥ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chapel Hill Nursing & Rehab 4511 Robeson Road Randallstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🕅 Other (Specify) in state 21. Signature of Emeral Service Licensee Ronald . Wade State Anatomy Board 655 W. Baltimore Street rector min Baltimore, MD 21201 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, ownear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary lear) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or): Due to (or as a consequence of) by Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Year 4☐Pregnant at time of death Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Uursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Delatural 2 Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 I Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 362 Solazar 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State DEC 0 4 2006 Registrar

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Norman Tyrone Stepney 1- For State Certificate of Death Registrar 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day November 8, 2006 Medical Examiner Norman Tyrone Stepney 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** reign CountryMaryland Months Days Hours June 15, 1957 Director 49 217-74-7131 1X M Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'n Yes 2 X No or items 23a or 28a-f show Calvert Prince Frederick MD permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho rigury or other reaunatic event, the Medical Examiner must be notified at once. Director 10e. Street and Numbe 10a. Citizen of What Country 20610 USA 6886 Hallowing Lane Funeral Was Decedent Ever in U.S 13. Was Decedent of Hispanic Drigin? (Specify Yes or No 14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married Yes 2 X No Divorced If Yes, Give Year Widowed 1 Yes 2 X No specify: Specify: black ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DD NDT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 8 0 disabled none 18.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Norman Stepney Melina Dixon Be 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Jack Makall/brother P.O. Box 1881 Prince Frederick, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State crematory or other place) Donation 5 X Other Specify: in state 21. Signature of Funeral Stryice Licensee Rone d S. Warde, ²² Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Baltimore, art I. Enter the disease, or comb that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** re. List only one cause on each line /Medical Death a. Pneumonia Immediat Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Discass or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED the attending physician and for use as the bunal -X AMENDED #2,23a,PII,27,perME, g863 1/10/07 TT Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O.
Hospital or Attending Physician: The law requires that the
24 hours after death.
Funeral Director: After this certificate has been signed by t
effect by the funeral director, page 2 should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Yes 2 No 3 Probably 4 V Unknown Intracranial hemorrhage due to hypertensive cardiovascular dis Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? ✓ Yes 2 No 1 🗸 Yes 2 No 25 Was case referred to medical 26.Place of Death (Check only one Be examiner? Hospital: 1 Inpatient 2 🖊 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending Accident 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical within 2 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 17, 2006 30 Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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he Hospit in 24 hour he Funera	Medical (29a. Certifier 1 Certifying (Check only one)	Physician: To the be xaminer: On the bas and manne	is of examin	owledge, death ation and/or inv	occurred restigation,	at the time in my op	e, date and pla inion, death oc	ice, and due to the	e cause(s) and ma e, date and place,	anner as stated. and due to the cause(s)	
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(5)		30. Name and address of person w		of death (Ite		Print)		,	17 212			
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Н			5. Social Security Number 6. Sex 7. Age (In yrs. last birth	If Under 1 Year If Under 24 Hrs.	B. Date of Birth (Month, Day, Yea	9. Birth	nplace (State or Foreign intry)
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	yland		10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
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	2 should be itied within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Iteme 23s or 28s-f ehow sumatic event, the Muchtal Expirite mark to notified a	F		Mailing Address (Street and Number or Rural	Route Number, Cit	y or Town, State, Z	ip Code)
Š	~ ~ ~ ~		Betty A. Smith / Wife 113	14 Rosanda Ct., Middl	e River,	Maryland	21220
ก	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. I them 23 or 28a-f show litem 27 is marked other than "natural", or Iteme 23a or 28a-f show rether treamatic event, the Mudical Examiner must be notified at		compten	Disposition (Name of place)	1te 20c.	Location - City or	Town, State
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altimo	그 문문을 .		21. Signature of Funeral Service Licensee	22. Name and Address of Facility McComas Funeral Hom			<i>,</i>
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Ö	Phys r this ral di	. To	27. Manner of Death 28a, Date of Injury 28b. T	ime of 28c. Injury at 2	8d. Describe how in		sny)
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DIVISION	al or Attending s after death. Il Director: After id in by the fune	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, fai	rm, street, factory, office	8f. Location (Stree City or Town, St	and Number or Ru	ıral Route Number,
5	a after	Certification:	4 Homicide determined building, etc. (Specify)		City of Town, S	(410)	
	To the Hospital within 24 hours of To the Funeral completely filled		29a. Certifier 1 Certifying Physicien: To the best of my knowledge (Check only 2 Medical Examiner: On the basis of examination and	, death occurred at the time, date and place, a	nd due to the cause	e(s) and manner as	stated.
	he Ho n 24 he Fu	Medical	(Check only 2 Medical Examiner: On the basis of examination and one) and manner stated.				
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Σ	29b. Signature and title of certifier	29c. License number	. 1	Date signed (Mont.	
ı			I Chati Desen, Medical Doct	or 0646++	N	ovember	28,2006
	100		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1. 1. 1	010 21	,
	4		Arati Desai 401 N. 1920	Adway DAltiMONE, /	ALY IAND	21231	
		ate	31. Date filed (Month, Day, Year) / 32. Registrar's Signature				
	Regist	rar	DEC 9 4 2008 Marie At	DOONE			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Zella Nov 28. Η. Stetler 2006 8:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton8. Date of Birth (Month, Day, March 7 If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Birthplace (State or Foreign Country) 1□M 1/1 Months Davs Hours Min. 86 Director 1920 Virginia 224 16 2479 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 10612 Thrift Road 20735 "natural", or items 23a United States within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2**XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White þ 3 V Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Homemaker</u> Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other i any Injury or other traumatic event, <u>tr</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hansen H. Fitton Mary Jane Mudd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lewis Stetler (son) 13457 Poplar Hill Road, Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec 4, 2006 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Øther (Specify) Fort Lincoln Cemetery 21. Signature of Funda Service Vicense 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road. Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach, ine. Immediate Cause (Final disease or condition resulting in death) **Physician** o de /Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown the signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 1∐ Yes 2X No Hospital or Attending Physician: 'ector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 2 After this 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) within 24 hours after death.

To the Funeral Director: Aft М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address

10403

31. Date filed (Month,

Year)

06

Cliniton

person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

			For State	State	of Maryl	and / Depa	artment rtificate			Mental H		00	0.6	3842	5
Π,		w	Registrar 1. Decedent's Name (First, Middle	e. Last)		Cei	uncau	OIL	Jean	2. Date of		Ng.	UO	3. Time of Dec	ath
	Physici		Marie E	,	т	ernullo				Novem		Day 20	Year	10:30 A	
Y	/Medio		4a. Facility Name (If not institution	<u> </u>		CINCILO	4b. City,	Town, or	Location of Deat		Del		y of Death	10.30 8	7
	Zamin		13010 Claxton	Drive				Laur	el			Princ	e Geo	rges	
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 X F	7. Age (In	yrs. last birthday)	If Under Months	1 Year Days	If Under 24 Hrs Hours Min.	(Month,	Birth Day, Y	ear)		lace (State or Fo	oreign
	Director		069-18-3889	1 W 2017	83	Yrs.				Feb.	2,	1923			York
	and and t		Usual Residence of Decedent 10a. State 10b. County		10c	. City, Town or Lo	cation							0d. inside City L	imits
Mary -f sho	Mary -f sho fied a	tor	MD Prince	Georges		Laure1								X□Yes 2[□No
	r 28a	Director	10e. Street and Number		L		10f. Zip	Code			10g	. Citizen of	What Cou	ntry?	
	th with	al D	13010 CLaxt	on Drive								ited	State	S	
	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at	Funeral	11. Marital Status	12. Was De	cedent Ever	in U.S. 13.	Was Deced	ent of Hi	spanic Origin? (S n, Mexican, Puer	pecify Yes or to Rican, etc.)	No-		ce - Americ		
20	s afte ; or it amin	by Fu	1 Never Married 2 Marr	if Yes, G			1 ☐ Yes 2	_	Specify:	,		Speci		White	
5-0036	hours tural' al Ex	q pe	3 Widowed 4 □ Divorced 15. Decedent	Year or I	Dates:	16a Decer	dent's Usua	I Occurs	ation		16		Business/In		
Ċ	within 72 ene. than "na he Medic	Completed	(Specify only highes	st grade completed	<u></u>	(Give	kind of wor DO NOT us	k done o e retired	luring most of wo.)	rking	10	o. King of E	ousiness/in	uusiiy	
7	yiene giene r thai	шo	Elementary/Secondary (0-12)	College	(1-4or 5+)	A	dmini	stra	tive Ass	istant		Supe	rior	Courts	
land	be filed within 72 horal Hygiene. ed other than "natu event, the Medical.	Be C	17. Father's Name (First, Middle,	Last)					18. Mother's Nar	ne (First, Midd	ile, Ma	iden Surna	me)		
<u>a</u>	should b and Ment marked umatic e	To	William Orgek						Ann Se	tlock					
Mar	2 shc and is ma		19a. Informant's Name/Relations	nip (Type. Print)		19b. Mailir	ng Address	(Street a	and Number or R	ural Route Nur	nber, C	ity or Towr	n, State, Zip	Code)	
	ges 1 and 2 should nt of Health and Mer I if item 27 is marke or other traumatic		Carole Novak	<u>- Daughte</u>	er	3255	1 S. W	l. Ri	viera Lan					DR 97070	
0	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 □ Burial 2 □ Cremation		n State	b. Place of Dispo cemetery, crei	natory or of	ther plac	θ)	Date	20	c. Location	- City or To	wn, State	
altimore,	it. Pa rtmer rtant: njury		4 ☐ Donation 5 ☐ Other (S		I N	letro Crema		d Addros	Dec	. 3, 200	s c	atonsv	ille, l	1D	
g	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Furnial Service	5 his	Mr.	7	601 Sa	andy	Spring F1	Road Fu	nera	HB	ne		
1			23a. Parti Enter the disease, or shock, or heart failure. List	complications that	caused the									Approximate Interval Betwee	
	Physician		Immediate Cause (Final disease or condition	only one cause on	each line.	Sta	90	1	Penal	Dis	Cec	020	1	Onset and Deal	
	/Medical		resulting in death)	Due to	(or as a con	sequence of):	10							9 100 11	2
	Examiner		Sequentially list conditions,	b									,		
	pa tis	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a our	sequence of):							- 1		
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200	ificate g physas the	edic		0.											
X Q Q	w requires that the death certifi been signed by the attending I should be detached for use as	Physician/Me	iF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome pf probirth 2 🔲		Ectopic pre	0.00000				23d. Da	ate of delive	ery	
<u>n</u>	death	sicie	in the past 12 months? 1 ☐ Yes 2 🗹 No		gnant at time		Other (spe				-	M	onth	Day Year	r
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VII	n: The ficate har, r, page		05.11							1□ Yes	2	LHO	1 ☐ Yes	2 □ No	
	Physician: The lav this certificate has ral director, page 2 a	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient	2 ☐ ER/Outpatier	* 2 DO	Δ Othe	26. Place of Dea						
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0	nding Ith. r: Afte e fun	atior	1 ☐ Natural 5 ☐ Pendin 2 ☐ Accident investig	9 '	nth, Day Yea	r) Injury	М		:? ∕es 2 □ No						
UNISION	r Atte er dea recto by th	tifica	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	inod 20e. Plac	e of injury - /	At home, farm, str	eet, factory	, office		28f. Location City or 7	(Stree	t and Num	ber or Rura	l Route Number,	
5	ital or rs afte ral Di	Certification:								Oily of 7	01111, 0	nato)		_	- 4
	To the Hospital or Attending Phys Within 24 hours after death. Ye the Funeral Director: After this completely filled in by the funeral directal	Medical		g Physician: To the	basis of exar										
	thin 2 the 3 the omple	Med	29b. Signature and title of certifie		nner stated.		29c	License	number		29d	Date signe	ed (Month,	Dav Year)	
1	FEX 8		A Comment				1			6					06
1	6		30. Name and address of person	who completed cau	use of death	Item 23a) (Tyne	Print)		000						
			20. Name and todiess of Pson	VI Pa	\$ 51	MD,	8609	;	865 Gecord	Ave	6	alver	Grid	mo	
V	Sta		31. Date filed (Month, Day, Year)	32.	Registrar's S	MD ignature	20						4.7	2091	0
	Registr	ar	DEC 0 4 21	JUD JOSE	had do	A STATE OF THE PARTY OF THE PAR									

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 38426

			I - For State Registrar			Cei	rtificate o	f Dea	th			F	Reg No.			004	_ (
	Physicia		Decedent's Name (First, Mi	dle,Last)								Date of De	ath			3. Time of Death	
l ledi	ical Exami	nor	G 11-1-	m'								Month Novembe	Day er 27, 2	006 Year		1744 hrs	
سأش			Scottie I 4a Facility Name (if not institu	tion, give st	norne reet and nu	mber)		4b. City,	Town, or Le	ocation of E				County of	Death	•	
			2 Wickman Court					Win	dsor Mill				В	altimore	Cour	ity	
	Funeral		5. Social Security Number	6 Sex		7 Age (In yrs. I	ast birthday)	If Un	der 1 Year	If Under 2	24Hrs 8	8 Date of B	irth (MM/E	DD/YYYY)	9. Birth	place (State or	
	Director		225 04 5265	v		3	6 4	Mon	ths Days	Hours	Min.	April	20.	1970	Foreign	West	
		-	235-04-5365	1 🗘 M	2F		Yr O	S.						13.0		wirgini.	<u>a</u>
	<u> </u>	H	Usual Residence of Decedent 10a State 10b Coun	V		10c. City	, Town or Loca	tion						_		10d Inside City Lir	nits
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	Mary 28a d at	환	10e. Street and Number					10f. Z	ip Code					en of Wh		-	
	ith the Maryland 23a or 28a-f sho		2 Wickman Cour	t					212	44			Uni.	ted :	stat	es 	
	5 72 hours after death with the Maryland n "matural", or items 23a or 28a-f she al Examiner must be notified at once	Funeral	11. Marital Status		2. Was Dec Armed Fo	edent Ever in U	in U.S. 13. Was Decedent of Hispanic Origin? (Specifing Vision of Hispanic Origin) (Specific Cuban, Mexican, Puerto Rice)									an Indian, Black,	
	death or ite nust	اج	1 Never Married 2	Married 1	Yes	2 No	l					Jan, 1919.		************		1	
	after al", c	Ð.	3 Widowed 4 X	Divorced If N	res, Give Yea Dates:	r			2 X No					Specify:	Whi		
	5-0036 Filed within 72 hours after Hygiene Gother than "natural", o the Medical Examiner r		15. Decedent's Education (S	pecify only I			16a Decede		al Occupation orking life. [16b. K	ind of Bus	iness/In	dustry	
	72 h	ete	Elementary/Secondary (0-1	2)	College (1	-4 or 5+)						,					
	215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica	Completed	12				Ser	Vice	Tech					Sea:	rs_		
,	5-0 led v Hygi othe		17. Father's Name (First, Mide	lle, Last)					18			irst, Middle,		Surname)			
	21215-00 ould be filed with I Mental Hygiene s marked other ic ic event, the Me	Be	Ralph Edward									a Haro					
	imore, MD 2121 Pages I and 2 should be fi nent of Health and Mental I tant: If item 27 is marked or other traumatic event,	ို	19a Informant's Name/Relation				100	-				al Route Nu					
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	more, MI Pages I and 2 s nent of Health a ant: If item 27		20a. Method of Disposition 1 X Burial 2 Crema	ion 3	Removal fro	om State	Place of Dispo crematory or o	ther plac	e)	-					,		
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	Baltimore, permit Pages I ar Department of Her Important: If ite		21 Sunature of Funeral Serv		,	M01113	22.	Name ar	nd Address o	of Facility	Basa	agic E	uner	al H	ome		
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	Physician		23a Part I. Enter the disease			aused the death	n. Do not enter	the mod	e of dying, s	uch as card	diac or re	espiratory a	rrest, sho	ck, or hea	rt	Approximate Inte	rval
	/Medical		failure. List only one cau	C		d to the Che	est									Death	ario
	Examiner		Immediate Cause (Final disea or condition resulting in death			consequence											\neg
			On a salid list and disease	b.													
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	Sox 687 leath certific e attending for use as t	ian	past 12 months?		1 Live b ⊿ Pregr	orth ant at time of d	anth =	etal deat other (S)	,	_Ectobic b	negnanc	-у		MOULL	D	ay roun	- 1
	Box 68 e death certi the attendin ed for use a	/sic	1 Yes 2 No 9	Jnknown	9 Unkn		<u> </u>	iner (S	Decity)				Ť				
	b. Be the de by the	듄	Part II. Other significant cor	ditions co	ontributing to	death but not	resulting in the	underlyi	ng cause giv	ven in Part	l.	23e. Did	tobacco (use contril	oute to the	ne cause of death?	?
	ires that the signed by											1 🗌 Y	es 2 🗸	No 3	Proba	ibly 4 Unknow	wn
	S, quire: en sis	Completed by									_	24a Wa	s an	24b W	/ere auto	opsy findings avail	able
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	Rec The la sate h	E										1 Yes			✔ Yes	2 No)
	Vital Rec ysician: The l his certificate l	Be C	25. Was case referred to med	_						of Death (C	heck on	ly one)					
	Vita ysici his ca direc	To B	examiner? 1 Yes 2 No	Hos	ipital: 1	Inpatient 2	ER/Outpatie	nt 3	DOA	other 4	Nursing I	Home 5	Reside	nce 6 🗸	Other:	Scene	
	ing Ph After t funeral	<u>ا</u> ا	27. Manner of Death		28a. Date	of Injury	28b. Time o	Injury	28c. Injury	at Work?	20	8d. Describe ubject Sta	how inju	ry occurre	ed		
	endir ath.	ţi		ending	Nov 27,	n Day, Year) : 2006	FOUND: 1728 hrs		1 Ye	es 2 🗸 N	10	ubject sta	abbeu				
	ivision or Attendafter death Director:	fica		vestigation	28e Plac	e of Injury - At h		eet, facto	ory, office bu	ıılding etc.						al Route Number,	City
The strain of th								∕IiI, Md.									
	tospi 4 hou iuner	29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.									ed.						
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical		xaminer:0	n the basis	of examination											
	To To	Mec	29b Signapure and title of de		nd manner s	stated		12	29c License	number			29d. [Date signe	ed (Mon	th, Day, Year)	
_		O.C.M.E. November 28, 2006								06							
	No.		7100	10			m 02e)										
	6		30. Name and address of per Susan Hogan MD.		1	se of death (Iter cal Examine		nn Str	eet, Baltii	more MI	D 2120	01					
			Of B to float the the Book								1 _ \						
	S	tate		ar) 1 2009	W.	egistrar's Signa		che?									

06-09069 Ellen M. Tribble

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 38427

	Remetter	ficate of Death	Reg. No.	00 0042				
Physician/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year November 28, 2006	3. Time of Death 1552 hrs				
edical Examine	ELLEN M. IRIBBLE 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea						
	3301 Oakfield Road	Baltimore	N					
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last	Months Days Hours M		eign				
pilector	215 · 18 · L495 1 M · 2 M F 83 Usual Residence of Decedent	Yrs.	01-10-1923	Country) MD				
Aue	10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limits				
faryland 28a-f show 1 st once. ector		IN OAK	10g. Citizen of What Co	1 Yes 2 K No				
or 25s	3101 OAKFIELD AVENUE	21207	USA					
215-0038 be fled within 72 hours after death with the Maryland nial hygiene. rked other than "matural", or items 23a or 23a-f sident, the Medisa. Expaning must be partified at once Be Completed by Furneral Director	11. Marital Status 12. Was Decedent Ever in U.S.	MODEL BY THE STREET STREET, SAN THE STREET STREET, SAN THE STR	Specify Yes or No- 14. Race - Am	erican Indian, Black,				
or items 23	1 Never Married 2 Married Armed Forces? 1 Yes 2 1 No	1 Yes 2 No specify:	Specify: BL					
urs after cural",	3 💽 Widowed 4 Divorced If Yes, Give Year or Date: 15. Decedent's Education (Specify only highest grade completed) 1	6a. Decedent's Usual Decupation (Give kind o	of werk done 1 ôb, Kind of Busines					
72 hour	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use r						
5-0638 led within 7. Sygiene. other than the Medica.	12. TH GRADE NA A 17. Father's Name (First, Middle, Last)	REGISTERED NURSE	Me (First, Middle, Maiden Surname)	BALIAL				
21215-(uld be filed a Mental Kyg marked oth c event, the	WILLIAM WILSON	MARGU	ARITE WILLIS					
AC 21 2 should h and Mer 27 is can imatic ev	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number of						
1 2 2 2 2 2		4563 DERBY MANOR ace of Disposition (Name of cemetery,	Date 20c. Location - City					
more Pages 1: nent of H ant: If it	1 W Bunal 2 Cremation 3 Removal from State	ematory or other place) DLAWN 12	.07:07 BALTIMOR	E MO				
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr	21. Gignature of Funeral Service Licensee	22 Name and Address of Facility VAUGHN C. GREENE F	UNERAL SERVICE					
	23a. Part i. Exter the disease, or complications that caused the death. D	5151 BAUTO, NIATL' PIK	CE BALTO MD 21229	Approximate Interval				
Physician /Medical	failure. List only one cause on each line.	rotic Cardiovascular Disease		Between Onset and Death				
≟xaminer	or condition resulting in death) Due to (or as a consequence of):							
- La	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):							
amine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
executed an and al - transit	d.							
760, icate be executed physician and the burial - transit	UNPENDED AMENDED		Logical					
1876 rtificate ing phy as the t	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant in the past 12 months?	2 Fetal death 3 Ectopic preg	23d. Date of deliv gnancy Month	ery Day Year				
Box 687 ce death certifit the attending ted for use as t hvs.ician/	1 Yes 2 No 9 Unknown a Unknown	h 5 Other (Specify)						
O. Bo at the de 1 by the tached f	Part II. Other significant conditions contributing to death but not res	uiting in the underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?				
Records, P.O. The law requires that the take that been signed by page 2 should be detach.			1 Yes 2 No 3 P					
Records, The law requires ficate has been sig				autopsy findings available o completion of cause of ?				
tal Recition: The location, page	OF War and referred to prefice!	26.Place of Death (Cher	1 Yes 2 No 1	Yes 2 No				
Civision of Vital Records, tall or Attending Physician: The law requires and effection. As a birector: After this certificate has been seed in by the funeral director, page 2 should britication: To Be Committee.	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 E	Othos	sing Home 5 Residence 6 Ott	ner: Scene				
ding Ph. After tl funeral	27 Manner of Death 28a Date of Injury 2	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred					
ivision or Attend after death. Director: Jin by the f	2 Accident S Pending Investigation	1 Yes 2 No	28f Location (Street and Number or	Rural Route Number City				
Division o spital or Attending tours after death. The filled in by the fure Cortification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)							
8 - = >1	1 203 Certifier	, death occurred at the time, date and place, a	and due to the cause(s) and manner as st	tarted.				
To the Howithin 24 To the Forcempletel	one) 2 Medical Examiner: On the basis of examination and and manner stated.	Mor investigation, in my opinion, death occurre	d at the time, date and place, and due to					
d 2	29b. Signature and title of certifier 29d. Date signed (M) November 29, 2							
	30. Name and address of person who completed cause of death (Item 2	3a)						
3	Pamela E. Southall, MD Assistant Medical Exam	iner 111 Penn Street, Baltimore.	, MD 21201	_				
Stat	31. Date filed (Month, Day, Year) 32. Redistrar's Signature	H Acarl 8						

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jai Lavic Pinnok (Tapper) Vear **Physician** 9:32am MOV. 23 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Baltimore AGNes Baltimore 5. Social Security Number UNK 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F 0 Vrs Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Hygiene. other than "natural", or Itams 23a or 28a-f show ent, the Madical Examiner must be notified at Maryland Baltimore Baltimore 1 Tyes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4746 Westland Blvd. 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: African/Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) No Occupation None 0 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should ba filment of Haalth and Mental H tant: If item 27 Is marked of Pete O'Neil Pinnock Natasha Tapper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Natasha Tapper/Mother item 27 l 4746 Westland Blvd. Baltimore Maryland 21227
use of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important; if its any injury or otl once. 1 Burial 2 Cremation 3 Removal from State New Cathedral Cem. 12/02/2006 Baltimore. Maryland 4 □Don tion 5 □ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home. Inc. 21. 3 gnature of Funeral Service Licensee 4107 Wilkens Ave. Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician severe worsening pulmonary interstitial emphysema 16 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): distress syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine weeks Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No Vital 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ✓ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ŏ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the the 29c. License number 29b. Signature and title of certifier Iner Synwong Neonatologist 1023368 23/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore St Agnes Hospital, 900 Caton Avenue. WONG MD21229

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

DEC 0 4

2006

8

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 8:30 AM M Amos Thompson November 22, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Medical Center Prince George's Cheverly 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1⊠M 2□F Yrs. 82 Director Nov 5. Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Exercises. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2√ No DC Washington Funeral Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4700 Kane Place NE 20019 IISA 14. Race - American Iridian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status unk 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specity: Specify: black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eloise McNeal/friend 4700 Kane Place NE Washington, DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ▼Other (Specify) in state 21. Signalure of Funeral Service Ronal State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 21201

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Baltimore, MD Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ng physicien and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Completed by Physician/Medical use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2□ No 1 Yes Division of Vital 25. Was case referred to medical examiner?
1 □ Yes 2 □ No Be director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ rpatient 2 ER/Outpatient 3□ DOA this 28b. Time of 27. M nner of Death 28d. Describe how injury occurred Medical Certification: After 1 Natural 2 Accident 5 Pending after death.

Director: After din by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Demetrios James Catevenis Cheverly, Md 20785 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 0 4

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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	1- For State Registrar		Certifica	ite of Death			eg. No	000 3843	
Physician/ Medical Examiner	Decedent's Name (First, Midd		•			Date of Dea Month	Day Year	3. Time of Death 2143 hrs	
Medical Examiner	DENNIS KETH 4a. Facility Name (if not institution)	n give street and number)		4b. City, Town,	or Location		r 27, 2006 4c. County o		
	3806 Old Frederick R			Baltimore				NA	
Funeral	5 Social Security Number	6. Sex 7. Age (I		rth (MM/DD/YYYY)	Birthplace (State or Foreign				
Director	212.84.0661	1 0 M 2 F	ble	Yrs. Months D	ays Hours	Min. 05.03	05.03.1970 Country) MD		
8	Usual Residence of Decedent 10a, State 10b, County	I10	c. City, Town o	or Location				10d Inside City Limits	
I IOW any	l mo	, 1	BALTIMO					1 X Yes 2 No	
aryland 8a-f show at once.	10e. Street and Number	100	JAC IIII	10f. Zip Code	e	1	0g. Citizen of Wh	at Country?	
th the Maryland 23a or 28a-f sho notified at once.	2528 W. LAFA	YETTE AVENUE		212	16		นธ	Α	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status	12. Was Decedent Eve				gin? (Specify Yes or No	14. Race White	- American Indian, Black,	
or ite	1 Never Married 2 N	1 Yes 2	No						
rs afte	45 December 19 Education (Co.	vorced If Yes, Give Year or Dates: ecify only highest grade comple	ted) 16a D	1 Yes 2 🗸 I			Specify 16b. Kind of Bus	BLACK iness/Industry	
1215-0036 Idee filed within 72 hours after found Hygiene narked other than "natural" event, the Medical Examine o Be Completed by	Elementary/Secondary (0-12)			uring most of working I			100.1010 01 000	in lood in success	
5-0036 led within 7 Hygiene other than the Medica	12 TH GRADE	NA	PA	AINTER			CONTR	ACTING	
5-0 iled w Hygie I othe Co	17. Father's Name (First, Middle					r's Name (First, Middle,			
Should be fill and Mental H. 7 is marked natic event,	DENNIS EOWAR 19a. Informant's Name/Relation		19h	Mailing Address (St	ARLE	NE VENIS mber or Rural Route Nur	E FISHE		
and 2 should tealth and Me tem 27 is ma traumatic ev	DENNIS THOMP			313 BAKER		BALTO. MD	21216	, State, Zip Code;	
P p le m	20a Method of Disposition		20b. Place of	Disposition (Name of ry or other place)		Date		City or Town, State	
mor Pages ent of nt: If	1 Burial 2 Crematio 4 Donation 5 Other S	n 3 Removal from State		IMOUNT		12.04.06	BALTIM	DRE, MO	
Baltimore, permit. Pages I ar Department of He Important: If ite	21. Signature of Funeral Service		011201		ess of Facilit	UE FUNERAL			
	23a. Part I (Aer the disease, o	4		5151 BAUD	NATE	PIKE , BALTO	. mp 2	229	
Physician /Medical	23a. Part I. Enter the disease, o failure. List only one cause	e on each line.					est, shock, or hea	rt Approximate Interval Between Onset and Death	
Examiner	Immediate Cause (Final disease or condition resulting in death)	e a Narcotic (he		d cocaine int	oxicati	on		Deatri	
	Sequentially list conditions,	b	01100 017.						
iner	if any, leading to immediate	Due to (or as a consequ	ence of):						
red Insit Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of).						
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3760, ficate be execu g physician and s the burial - tra	X UNPENDED	AMENDED #23a	.27.28a-	f. perME. g86	2. 12/1	2/06 TT			
Sox 68760, death certificate be attending physici for use as the burnysician/Medysician/Medysician/Med	IF FEMALE: 23b. Was decedent pregnant in	the 23c. If yes, outcome of Live birth		Fetal death	3 Ectopi	c pregnancy	23d Date of o	delivery Day Year	
Box 68 Box lost	past 12 months?	4 Pregnant at tim	e of death 5	Other (Specify)					
). Box 68 the death certification by the attendin to the death for use a Physicial	Part II. Other significant condi	9 Onknown	it not resulting	in the underlying caus	e given in P	art I 23e Did t	phacco use contrib	oute to the cause of death?	
, P.O. Be ires that the de signed by the I be detached f		nons contributing to death be	at not resulting	The anderrying cade	e given iii i			Probably 4 V Unknown	
Records, P.(The law requires than ficate has been signed . page 2 should be det. Completed by		·						ere autopsy findings available	
COr e law r e has b ge 2 sh	i ———			-			rmed? de	ior to completion of cause of eath?	
Vital Rec	25. Was case referred to medic	al		26.Pla	ace of Death	(Check only one)	2 No 1	Yes 2 No	
Vital ysicians his certi director	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/Ou	tpatient 3 DOA	Other ₄	Nursing Home 5	Residence 6	Other: Scene	
n of Vi	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. T		njury at Worl		how injury occurre	d	
sion trendi death etor: y the f	1 Natural 5 Per 2 Accident Inve	Fnd 11/27/2		IIOWII	Yes 2 X	tulk itowii			
Division of Vital Records, P.O. sprinal or Attending Physician: The law requires that the hours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be deated. Certification: To Be Completed by P.	3 Suicide 6X Cou	ald not be		rm, street, factory, offic	e building, e	tc 28f Location (or Town, \$	Street and Numbe State) 3006 0	or Rural Route Number City	
ospita hours uneral ly fille	4 Homicide 29a. Certifier 4 Continues I	ermined (Specify) He Physician: To the best of my ki	ome	th occurred at the time	date and al	Baltimore		as started	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn Medical Certification: To Be Completed by Physician/Med	(Check only one) 2 Medical Ex	aminer:On the basis of examin							
To Sol	296. Signature and title of certif	and manner stated		29c. Lice	ense number		29d Date signe	d (Month, Day, Year)	
	(Dawker	be www)		0.0	C.M.E.		November 2	28, 2006	
T		n who completed cause of deat		Donn Ctarat Dal	timas == 1	ID 21201			
		Assistant Medical Exam		Penn Street, Ba	ilimore, N	וט צוצט ו			
State Registra		1 2006	Signature &	porte					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month **Physician** NOVEMBER 25 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL BALTIMORE SAINT AGNES If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 153-34-7661 Director MARYLANCE Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Funeral Director BALTI MORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ACTORY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mportant; If item 27 LACQUELINE. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Injury or 1 ■ Burial 2 □ Cremation 3 □ Removal from State Braklyn, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee romartu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CELL LUNG CARCINOMA **Physician** NONSMALL 1 YEAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by THROMBOUTOPENIA HEPARIN INDUCED 1 Yes 2 No 3 Probably 4 Unknown CHRONIC KIDNEY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy perform certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No npatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death
Natural
2 Accident 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I 29c. License number 29d. Date signed (Month, Day, Year) P 18606 NOVEMBER, 25, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), AJJAI ALVA, 900 CATON AVENUE, BALTIMORE, MD 21229

TAYLOR, LORETT

31. Date filed (Month, Day, Year) DEC 0 4 2006 900 282. Registrar's Signature

Registrar

		Į,	- State	State of Maryland	d / Depa	rtment of H	lealth and I			38432
			Registrar 1. Decedent's Name (First, Middle, Last)			incate of i	Joan	2. Date of De.	Reg. No. ath	3. Time of Death
	Physici		Janet Gift Thomas	9				Nov. 3	0, ^{Day} 2006	6:50P M
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Death		4c. County of De	
40		33	Wilson Health Ca			Gaithe	rsburg		Montgo	mery
	Funeral		5. Social Security Number 6. Sex	M 21XF 7. Age (In yrs. Ia	st birthday). Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da	y, Year)	inhplace (State or Foreign Country)
i de	Director		034-38-3816 Usual Residence of Decedent	86				⊥Mar. 1	9, 1920 Pe	ennsylvania
	death with the Maryland ms 23a or 28a-f show tunnt to indiffed at		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Ba-1s	Director	Maryland Montgomer	ry Gait	thersb					1 Yes 2 No
	with th		10e, Street and Number	"04 /		10f. Zip Code	-		10g. Citizen of What	
	eath v	eral	407 Russell Avenue	2. Was Decedent Ever in U.S	13 V	2087		necify Yes or No	United S	tates
0	fter d	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		Vas Decedent of H Yes, specify Cuba		o Rican, etc.)	Black, Wi	
200	hours after tural', or Ite al Expresse	by	3 Nidowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Specify:	Mite
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7 0	i Hygie other	CO	17. Father's Name (First, Middle, Last)	4	Graph	ic Artis			Defense (ontractor
<u> </u>	fental fental rked ric ev	To Be	Raymond S. Gift	t			Dorot	by Brad	shaw	
Mary	and N		19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street			er, City or Town, State	, Zip Code)
Σ. Σ	s 1 and 2 f Health ftam 27 other tra		Anne T. Lane/Daug							lina 29715
E	ges 1 t of H if its		20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Re			sition (Name of natory or other place			20c. Location - City	or Town, State
ащи	it. Pages rtment of rtant: If It		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Sequence License	Cre	ematog	ium, Inc.	200)6	Rethesda.	Maryland uneral Home/
g	permit. Departm Importa eny Inju		Signature Street	3) 2000 MOOS	B	ethesda-	hevy Cha	așe, Înc	• 7557 Wis	consin Avenue
	STOR		23a. Part1. Enter the disease, or complic	ations that cau be the death.	Do not ente	ernesda. er the mode of dyin	g, such as cardiac	or respiratory ai	rest,	Approximate Interval Between
	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	Cornes	ten	chear	than	luce	,	Onset and Death
	/Medical		resulting in death)	Due to (or as a conseque	ence of):		0			
	Examiner	_	Sequentially list conditions, b.	deche	nic	Card	ion	yopa	they	
	led sit	nIne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence)	ence of):	arter	uder!	11.		
,	be executed sicien and burial-transit	Examine	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of		7			
2/20	cate be ex physicien the buria	dical	d.				•			
٥	death certificate e attending phys id for use as the	Medi	IF FEMALE:				_			
X O D	eath certific attending p	an/h	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pregnan 1□Live birth 2□Fetal o	death 3	Ectopic pregnancy			23d. Date of d	elivery Day Year
	the dea by the al	ysici	1 Yes 2 No	4□Pregnant at time of dea 9□Unknown	ath 5□	Other (specify)			I WOM	Day Feat
7.		by Physician/Me	Part II. Other significant conditions cont	inbuting to death but not resul	Iting in the ur	iderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
S	w requires that been signed b should be deta	d b	Recent Closts	ideadific	iles	elitis	atrical	101	/es 2 1 No 3 □	Probably 4 Unknown
Cord		olete	fibrillation.	hypeetis	Leon	arote	nie	24a. Was	an 24b. Were	autopsy findings available
Ž.	sician: The law certificate has briector, page 2 s	Completed	anensi sos che	wieden	uil	, Elide	rance	autop perfo 1 ☐ Yes	rmed?/ death'	completion of cause of
VItal	sician: certifica rector.	Bec	25. Was case referred to medical examiner?				26. Place of Dea			
0	Physician: this certific ral director,	은	1 Tyes 2 No		R/Outpatien		4 Thursing H		dence 6 Other (Sp	pecify)
Sion	ding After fune	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	yat k? Yes 2 □ No	280. Describe r	now injury occurred	
Š	Attending r death. sctor: After by the fune	flca	3 Suicide 6 Could not be	28e. Place of Injury - At hor	me, larm, stre				Street and Number or	Rural Route Number,
<u>≥</u>	ppital or ours afte leral Dire filled in b	Certification:	4 Homicide	building, etc. (Specify)	,			City or Tov	vn, State)	
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physic	cian: To the best of my know er: On the basis of examination	vledge, death	occurred at the tin	ne, date and place	and due to the	cause(s) and manner	as stated.
	To the Hos within 24 ha To the Fun completely	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License			29d. Date signed (Mo.	
	2 1 × 10	_	Harabert &		1111					
	127			npleted cause of death (Item	23a) (Type	Print) 201	DIVE	8////	15/11/10	
	1)		30. Name and address of person who con A. R.O.B.E.R.T.B.(R.S.) 31. Date liled (Month, Day, Year)	CHBACH, U	4	64	THERS	BURG	o, mil	208 2 7
100	Sta Registr		31. Date liled (Month, Day, Year) DFC 0 4 2006	32. Registrar's Signatu	Charle	9				

06-09131 Vernon R Vaden

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 38433

		1- For State Registrar		Certific	ate of l	Death			Reg N	lo		
Physicia		Decedent's Name (First, Midd						2. Date of Month		y Yea		3. Time of Death
Medical Examiı پىلىر	ıer	VERNON 4a. Facility Name (if not instituti		DEN		. City, Town, or	r Location o		mber 1,	2006 4c County of		0232 hrs
		1929 Eastern Ave	on, give street and number)			Baltimore	Location	or Death		N /		
Funeral		5. Social Security Number	6 Sex 7 Age	e (In yrs. last bir	thday)	If Under 1 Yea	ar If Unde		of Birth(M		g Birth	place (State or
Director		219-40-0157	1 X M 2 F	61	Yrs	Months Day	s Hours	Min 01/	21/1	945	Foreign TEN	WESSEE
à.	-	Usual Residence of Decedent 10a State 10b. County	,	10c City, Town	or Location)			_		1	10d Inside City Limits
daryland 28a-f show any 1 at once.		MD. N/	Δ	RΔI	TIMO	DF						1 X Yes 2 No
arylan	Director	10e Street and Number				10f Zip Code	-	· · · · · · · · · · · · · · · · · · ·	10g. 0	Citizen of Wh	at Countr	·y?
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Ö	1929 EASTER	N AVENUE			21:	231			U.8	S.A.	
th with	Funeral	11. Marital Status 1 Never Married 2 N	12. Was Decedent Armed Forces?	Ever in U.S.				in? (Specify Yes Puerto Rican, et		14. Race White		an Indian, Black,
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once			1 Yes 2 vorced If Yes, Give Year	X No	1 Y	es 2 X No	specify:			Specify:	WH	ITE
hours after 'natural",	g p	15. Decedent's Education (Spe	or Dates.		Decedent's	Usual Occupa	ition (Give I	kind of work done	16b	. Kind of Bu		
6 an "n ical E	Completed	Elementary/Secondary (0-12)) College (1-4 or 5	+)		t of working life	B. DO NOT	use retired)				
5-003 led withii tygiene other th	mo d	9 17. Father's Name (First, Middle	a Last)		LA	BORER	19 Mathor	's Name (First, Mi	ddlo Morde	STEE		
215-0036 be filed within 7 ntal Hygiene ked other than ent, the Medica	BeC	LEE VADEN	, 2007				MAI		NKS	on Surname,		
D 2121(should be fill and Mental F 7 is marked		19a. Informant's Name/Relations	ship (Type, Print)	19	b. Mailing A	ddress (Stree		ber or Rural Rout		City or Towr	n, State, Z	(ip Code)
e, MD 21215-0036 I and 2 should be filed within 72 Health and Mental Hygiene ifem 27 is marked other than " r traumatic event, the Medical.		CAROL GELDMA	CHER/SISTER					E RD., B				
Baltimore, M Definit Pages Land 2 Department of Health Important: If item 2 injury or other traun		20a. Method of Disposition 1 Burial 2 XXCrematio	n 3 Removal from Sta	te cremat	ory or other			Date		c. Location -		
timor t Pages rment of l		4 Donation 5 Other S		BAYVI		REMATO		12/2/0				, MARYLAND
Balti permit Departm Importa		21. Signature of Financial Service	Licensee	1	15T1	LY & Z	ZEILI PERN	ER INC.	FUN	ERAL	HOM	E D. 21231
Physician	7	23a. Part I. Enter the disease, o failure. List only one cause		the death. Do no	ot enter the	mode of dying,	such as ca	ardiac or respirato	ory arrest, s	hock, or hea	art T	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease	e a Hypertensive At		Cardio	/ascular Dis	sease					Death Death
		or condition resulting in death)	Due to (or as a conse	quence of):								
	le	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):				·				
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8760, tificate being physic as the bur	흴	IF FEMALE: 23b. Was decedent pregnant in t	the 23c. If yes, outcom		Fetal	death 3	Ectopic	pregnancy	2	3d Date of one Month	,	y Year
Box 68 e death certi	icia	past 12 months?	4 Pregnant at t			(Specify)		prognancy	- 4	WOTH	Day	. Teal
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e law re has b	g d								autopsy performed	? de	eath?	npletion of cause of
tal Recian: The certificate		25. Was case referred to medica	al			26 Place	e of Death (Check only one)	Yes 2 🗸	No 1	Yes	2 No
Vita ysicia ysicia his cer direct	o Be	examiner?	Hospital: 1 Inpatier	nt 2 ER/O	utpatient 3		Other ₄	Nursing Home	5 Resid	dence 6	Other: S	cene
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Division of Vital Records, Hospital or Attending Physician: The law require 24 hours after death Funeral Director: After this certificate has been si tely filled in by the funeral director, page 2 should b	Certification:	dete	28e. Place of Injudent particular (Specify)	ury - At home, fa	arm, street,	factory, office b	ouilding, etc		tion (Street wn, State)	and Number	r or Rural	Route Number, City
Hospit 4 hour Funers	္ခို	29a. Certifier	Physician: To the best of my	knowledge dea	ath occurred	d at the time da	ate and pla	ce and due to the	cause(s) a	and manner :	as started	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical		aminer:On the basis of exam and manner stated									
FSES	Me	29b. Signature and title of certific		·		29c. Licens			29d	l. Date signe	d (Month	, Day, Year)
19		Hamile Pourt	Well mo			O.C.I	M.E.		De	cember 1	1, 2006	
		30. Name and address of person Pamela E. Southall, M			r 111	Penn Street	t Baltim	ore, MD 2120	11			
Sta	ate	31. Date filed (Month, Day, Year)		. 0:	ah .		., Jailliíl					
Regist		DEC 0 4	200	12	Gasal	0						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 6 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10p Cora Washington 11 19 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges 9000 Briarcroft Lane Laurel 8. Date of Birth (Month, Day, Ye 05-06-1929 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 77 579-34-1342 1 □ M 2 🕅 F Illinois Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No MD Prince Georges Laurel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20708 U.S.A. 9000 Briarcroft Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married **BLACK** 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify Specify: ģ 3 Midowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Customer Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Boyce Durham Daisy Durham ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Lucretia Morris 11438 Laurel Walk Dr., Laurel, Maryland 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 12-13-2006 Arlington, VA Arlington National 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig - True of Juneral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Rd., Laurel, Maryland 20708 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) unknown **Physician** ac /Medical Due to (or as a consequence of): Examiner aor were Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown signed by t. I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate has 1∐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Certification: To 1 🔲 Inpatient 2 ☐ ER/Outpatient this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death After t Injury 1 XNaturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature Year)

pper Marlboro

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 9862 12-21-06 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Russell Lee Walters M DECEMBER 2. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye July 21, 5. Social Sept ty Number 6. Sex 7. Age (in yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1929 Maryland XXM 2□F 213-23-5706 77 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show 1 □Yes XXNo notifled Director Shrewsbury Pennsylvahia York 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 17361 U.S.A. 25 Plank Road or items 23a must 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 7 is marked other than "natural", or iten traumatic event, the Medical Examiner. XXYes 2 No 1948— If Yes, Give Year or Dates: 1951 Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 🗙 Yo Specify. þ ¥XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 'Department of Health and Mental Hygiene, Important: If item 27 is marked other than "any injury or other traumatic event, the Mec Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications 12 Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith Mae Becker Bennie Walters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 726 Delmar Avenue, Glen Burnie, Maryland 21061 Russell L. Walters, Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith Dec. 6,2006 Baltimore, Maryland 4 ☐ Donation — 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Pl el Service La ensee any il Figure the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of): Examiner MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine requires that the death certificate be executed CARDIOGENIC SHOCK that initiated events burial-trar and resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No P.O. 9□Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 MNo 24a. Was an page 2 s has autopsy performed? Yes 2 No certificate 1□ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury 27. Manner of Death 28h Time of 28c Injury at Work? 28d. Describe how injury occurred After t Certification: Division (Month, Day or Attending 1 (Natural 5 ☐ Pending investigation after death.

I Director: Af in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours after To the Funeral Dire the Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

Registrar
DHMH 17 Rev 1/2001

State

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32. Palistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HISROW TABASSI M. D
31. Date filed (Month, Day, Year) 32. F

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December

OSLER DRIVE TOWSON MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UUD 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Month Thomas F. Wisniewski, Sr. November 28, 2006 6:00 P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7819 Rockbourne Road Dundalk Baltimore Co. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 🔀 M 2 🗆 F Hours Min. Yrs. Director 68 219-26-7779 Mary 1 and Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Exeminer must be notified at Director 1 Yes 2 XNo Maryland Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 7819 Rockbourne Road United States Itama 23a 21222 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify; 3√Widowed 4 □ Divorced Specify "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Joseph A. Banks and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clothiers 12 Years Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unkn. Laura Szabelski 19a. Informant's Name/Relationship (Type, Print) Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Thomas F. Wisniewski, Jr. item 27 12 Oakway Road Lutherville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If its eny injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State □ Donation 5 □ Other (Specify) Sacred Ht. of Jesus Cem. 12/4/2006 Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death - Clardiounsulaidio Immediate Cause (Final A Rten scle Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Securation list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown

The law requires that the death certificate be executed þ Completed or Attending Physician: Be ပ္ After thi Certification: death. Director: / within 24 hours effer d To the Funaral Direct completely filled in by

Box 68760.

Division of Vital Records,

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 Ano 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of confider

When the second seco

30. Name and address of person who completed cause of deathy (Item 23a) (Type Print) Fosten Ave. 10mi)

State Registrar

31. Date filed (Month, Day, Year)



			For State Registrar	State of Maryland		rtment of H			ien@ 006	38437
	Physici		1. Decedent's Name (First, Middle, Last) LAW REA	CE W	/	OK		2. Date of Death Month	Day Year	3. Time of Death
	/Medio Examir			eet and number) CLURS Ho	Spita	4b. City, Town, or	Location of Death	PRE 8. Date of Birth	4c. County of Death	place (State or Foreign
12° 7	Funeral Director		5. Social Security Number 6. Sex 220-36-8571 St. Security Number 1	4 2□ F 65	Yrs.	Months Days	Hours Min.	Month, Day, Apr 22,	Year) Cou	ntry) unk
	the Maryland 28a-f ehow	tor	10a. State 10b. County MD		Town or Loc Baltim					10d. Inside City Limits 1 1 Yes 2 □ No
	with the 3s or 28s	i Direc	10e. Street and Number 1217 W. Fayette St:	reet		10f. Zip Code 21223	3	10	Og. Citizen of What Cou USA	intry?
36	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-1 ehow the Modesal Examiner filled be notified at	by Funeral Director		. Was Decedent Ever in U.S		/as Decedent of Hi Yes, specify Cuba ☐ Yes 2X No	ispanic Origin? (Spen, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	, etc.
21215-0036	within 72 hounde.	Completed 1	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give I	ent's Usual Occupa ind of work done of O NOT use retired	during most of works		6b. Kind of Business/I	ndustry unk
	ild be filed v lental Hygie ked other t lic event, III	To Be Co	unk un 17. Father's Name (First, Middle, Last)	K		unk	18. Mother's Name	(First, Middle, M	Maiden Surname)	unk
nore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Importents if item 27 is marked other then "natural", or items 23a or 28a-4 ehow mith jury or other treumatic event, its Medical Experiment must be notified at any injury or other treumatic event, its Medical Experiment must be notified at ance.		19a. Informant's Name/Relationship (Type Bon Secours Hospit 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re	a1 20b. Ph	2000 ace of Dispos		more Stre	et Balt:	City or Town, State, Zinore, MD 20c. Location - City or T	21223
Baltimore,	permit. Pa Departmen Importent eny injury		4 Donation 5 MOther (Specify) 21. Signature of Eureral Service Libenser Ronald W	in state ade Difector	St Ba	Name and Address ate Anato Itimore,	ss of Facility omy Board MD 2120	655 W.	Baltimore	Street
8760,	eath certificate be executed Ex Authorized and attending physicien and for use as the burnal-transit	dicai Examiner	23a. Part 1. Enter the disease, or complicion shock, oheart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. d.	Due to (or as a consequence to	ence of):	EMI	A		-ARCTIO	Approximate Interval Between Onset and Death
P.O. Box 68	ath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of delin Month	∕ery Day Year
	w requires that the de been signed by the s should be detached	Ď	Part II. Other significant conditions cont	ributing to death but not resu	ılting in the ur	derlying cause give	en in Part I.		acco use contribute to	
I Reco	The law recate hes bee page 2 sho	Completed						24a. Was ar autops perform 1 Yes 2	v prior to c	opsy findings available ompletion of cause of 2 No
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Certification: To Be	27. Mannar of Death 1-Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injun Work M 1	y at k? Yes 2 \(\text{No} \)	me 5 ☐ Reside 28d. Describe ho	ince 6 Other (Special of the control	
Οį	Hospital or 24 hours afte Funerel Dire tely filled in I	al Cert		building, etc. (Specify	wledge, death			and due to the ca	use(s) and manner as	
	To the Ho within 24 I To the Fu completel	Medical	(Check only 2 Medical Examination) 29b. Signature and title of certifier	er: On the basis of examinat and manner stated.	m.]	29c. License	e nu <i>m</i> ber	29	d. Date signed (Month	, Day, Year)
			30. Name and address of person who con	ripleted cause of death (trem	23a) (Type,	Print) BO	TH SE	cour	es Hosp	19,2006
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture	sees 8			,	

06-08812 Quintin Williams

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Rea. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day November 19, 2006 Medical Examiner 0819 hrs Quintin Williams
4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 3409 Duval Avenue Baltimore 5. Social Security Number unk If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or unk If Under 1 Year **Funeral** 7. Age (In vrs. last birthday) Months Hours Min Foreign Country) Director 1 X M 2 43 Yrs Apr 25. 1963 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD Baltimore Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyggene.
natt. If Item 27 is marked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Medical Examiner must be notified at once. Director 10e Street and Numbe 10f Zin Code 10g. Citizen of What Country? 3409 Duval Avenue 21216 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, unk Armed Forces? 1 Never Married 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 3 Widowed Divorced Yes, Give Year 1 Yes 2 X No specify: black Specify \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done ${rak unk}$ 16b. Kind of Business/Industry unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street Baltimore, MD 21201 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit Page:
Department o
Important: I Donation 5 X Other Specify: in state 21. Signature of Ruse | Service Licensee d 2State Affato My Board 655 W. Baltimore Street Director Baltimore, MD 21201 Physician Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval ilure. List only one cause on each line Between Onset and /Medical Death a Bronchopneumonia complicated by hypothermia Immediale Cause (Final disease *xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last pue Physician/Medical X UNPENDED tending physician a use as the burial -AMENDED #23a,27,28a-f, perME, g862, 12/16/06 TT The law requires that the death certificate be Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown Unknown ned 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica Division of Vital 26. Place of Death (Check only one) æ examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other Scene After this 1 Yes No 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Exposure to cold environmental hours after death. 5 Pending 1 Yes 2 X No the Fnd 11/19/2006 Fnd 8:00 am 2 X Accident temperature Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 3409 Duval Road Baltimore.MD (Specify) Found outside single family residen Homicide Baltimore. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical within To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 19, 2006 30. Name and address of person who completed cause of death (Item 23a)

OCME 2006

State Registrar

Carol Allan, MD

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_	For State Of IVI	aryianu /		rtificate of	Death	eniai Hy	glene Reg. No. 200	6 38439
- 1	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Ye	3. Time of Death
	/Medic		Aaron White 4a. Facility Name (If ngt institution, give street and number)		-	4b. City. Town, or	r Location of Death	NOV	24 06 4c. County of D	
	Examin	er	ST Agnes Hospiti	al			imore		10. 000111, 01 0	
	Funeral		5. Social Security Number 6. Sex 7. Ag 12-76-9135 1. Ag 1.	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da		Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	44				Sept 8	, 1962 Ma	ryland
	ryland show	_	10a. State 10b. County	10c. City, To	own or Lo	cation				10d. Inside City Limits
	he Ma Ba-f s otified	Director	MD	Ba1	Ltimo					1½ Yes 2 □ No
	with th	Ö	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	leath ms 23 must	Funeral	3110 Garrison Blvd 11. Marital Status 12. Was Decedent	Ever in U.S.	13. \		. 216 ispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No	USA - 14. Race - A	merican Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Yes, Given Year or Dates:	No		f Yes, specify Cuba	an, Mexican, Puerto Specify:	Rićan, etc.)	Black, W	
15-0	n 72 hc "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	1	6a. Deced	lent's Usual Occup kind of work done o	ation during most of working	unk	16b. Kind of Busine	ess/Industry un
72	l withir liene. r than the Ma	omp	Elementary/Secondary (0-12) College (1-4or s	5+)	mo, i	JO NOT use remed	"			
کو	e filec al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)	•				•	Maiden Surname)	
<u> a</u>	ould b Ments arked atic e	10	Otho White					res Lew		
Mar	12 should h and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type. Print)						er, City or Town, Stat	e, Zip Code)
e,	1 and Health tem 27 other tr		Gwendolyn Steele/sister 20a. Method of Disposition	20b. Place	e of Dispo	sition (Name of		rville,	NJ 08081 20c. Location - City	or Town, State
Baltimore,	it. Pages rtment of l rtant: If it njury or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state			natory or other place				
Bal	permit. Departr Importa any Injo		/ ann////Vill	ector	Ba	Itimore.	MD 21201	L	Baltimore	e Street
			23a. Part1. Inter the disease, ir o implications that caused shock, ir heart failure. List only one cause on each li	d the death. E	Do not ent	er the mode of dyin	g, such as cardiac c	r respiratory ar	rrest,	Approximate Interval Between
	Physician		Immediate C v. e (Final disease or condition resulting in death) a. Seve	re C	AI)				Onset and Death
	/Medical Examiner		Due to (or as	a consequen	ce of):	Q105				YPars
		Je.	Sequentially list conditions, law leaves to lor as cause. Enter Underlying Cause (Disease or injury that initiated events	a consequen	ce off.	1710)				Jar
	scuted nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
68760,	tificate be executed g physician and as the burial-transit	E E	Due to (or as	a consequen	ce of):					
687	ificate g phys as the	edical	d.							
O. Box	The law requires that the death cert te has been signed by the attending age 2 should be detached for use a	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
+ 4.	s that t ned by detac	y Ph	Part II. Other significant conditions contributing to death b	ut not resultin	ng in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute	e to the cause of death?
white ecords, F	equire; en sig ould bo	ed b						101	res 2 1 No 3 □	Probably 4 Unknown
æ	sician: The law r. certificate has be irector, page 2 sho	Complet						24a. Was autop perfor 1∐ Yes	rmed?/ death	e autopsy findings available to completion of cause of 1? 'es 2 \sum No
Vital	ysician: is certific director,	Be	25. Was case referred to medical examiner? Hospital: Hospital:			t 3D DOA Oth	26. Place of Death			
o S	Phys r this ral dir	은 -	27. Manper of Death 28a. Date of Injuri	iry 28	Outpatien b. Time of	· OLI BOX	4 Li Nuising Hor		dence 6 Other (S	Specify)
₹ <u>5</u>	Attending Physician: r death. sctor: After this certifica by the funeral director.	ation	1 Matural 5 Pending (Month, Da 2 Accident investigation	y Year)	Injury		k? Yes 2 □ No		. , ,	
$\mathcal{A}_{\mathcal{C}}$ Division	or Atterdes	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of inj building, et	ury - At home c. (Specify)	, farm, str	eet, factory, office	2	28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,
_	Hospl 4 hou Funer ely fill	Medical Ce	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best 2 ☐ Medical Examiner: On the basis of and manner st	f examination	dge, death and/or in	n occurred at the tirvestigation, in my o	ne, date and place, a pinion, death occurr	and due to the ed at the time,	cause(s) and manner date and place, and	r as stated. due to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Me	
			Fyad Alsheikh MD =			P	20966			24,06
_			30. Name and address of person who completed cause of a	Cat	00	AVE, Bo	altimore	, MD	21229	
	Sta Registr	-	31. Date filed (Month, Day, Year) 32-Registr DEC 0 4 2006	ar's Signature	Got	will s				:

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene factor of Health and Mental Hygiene Registrar #20a_c&22 Per FH g862 12/20/106 Jh Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Thomas Webb /Medical 4b. City, Town, or Location of Death, 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Jary land tin 9. Birthplace (State or Foreign Country) unk 8. Date of Birth Month, Day, Jan 13, If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year Days **Funeral** ^Y1943 1**X** M 2□ F 63 215-40-7163 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1700 Druid Park Lake Drive #804 21216 USA Completed by Funeral 12. Was Decedent Ever in U.Sunk 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Specify Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced unk 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) unk other than "natu (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 7 Is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) unk unk 17. Father's Name (First, Middle, Last) Be and Mental r 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health at Important: If Item 27 Is any injury or other trau once. Maryland General Hospital 827 Linden Avenue Baltimore, MD 21202 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Oremation 12/12/906 cemetery crematory or other place)
Bayview Crematory 3 ☐Removal from State 22 Name and Address of Facility MCCu Balto,Md 4 Donation 5 Meter (pecify) in McCully -Polynaik F.H. 21. Sign to of Funeral Service Licensee

Konald S. Wad Baltimore Street 130 East Ave. 21230 MI 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death tastati **Physician** disease or condition resulting in death) /Medical Dure to (or as a consequence of): **Examiner** eumoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and nding physician and use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2. No 1 ☐ Yes this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28d. Describe how injury occurred funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date, signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (The sum of the s

Year

32 Registrar's Signature

			1 - For State Registrar	State of Maryla		artment of Health rtificate of Death			m 0 0 0	38441
		m	Decedent's Name (First, Middle, Last	t)				Reg. I		3. Time of Death
H	Physicia /Medic		Kermit A. V	Unseles =	SR.		Λ	Nonth	24 2006	1025PM
2	Examin		4a. Facility Name (If not institution, give		1 3.7	4b. City, Town, or Location			c. County of Death	10
			University a Man	and Medica	l Susten	Baltin	ove		N	A
	Funeral		5. Social Security Number 6. S		rs. lasi birthday) Yrs.	If Under 1 Year If Under Months Days Hours	r 24 Hrs. 8 Min.	Date of Birth (Month, Day, Yea	9. Birth Cor	nplace (State or Foreign untry)
	Director		220-76-1112 Usuaf Residence of Decedent	20 M 2 D F 44	2 115.			05/06/19	940	MN
	/land		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Man B-f eh	tor	MD Paine G	eneges L	aurel					1 ☐ Yes 2 🛣 No
	th the	Director	10e. Street and Number	0		10f. Zip Code	-	10g. (Citizen of What Cou	untry?
	23a	ral	14200 Westmea	th DR.		20707		us	A	
	er deg	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13. \	Was Decedent of Hispanic Or f Yes, specify Cuban, Mexica	rigin? (Specif in, Puerto Ric	ly Yes or No- can, etc.)	14. Race - Amer Black, White	ican Indian, , etc.
36	rs aft	y F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		I ☐ Yes 2 ☑ No Specify			Specify:	a . V
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28a-f ehow ery Injury or other treumatic event, the Medical Examinal must be notified at once.	Completed by	15. Decedent's Ed	ucation	16a. Deced	lent's Usual Occupation		16b.	Kind of Business/	OCK ndustry
2	hin 7: 9. Medi	ple	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of work done during mos DO NOT use retired)	st of working			,
7	er the	Con	12 TH GRADE	Years	Paste	R		M	inistry	
nd	be file d oth	Be	17. Father's Name (First, Middle, Last)					First, Middle, Maid	en Sumame)	
₹	ould Men Marke Marke	ဥ	Kermitt Whee			Billie		more		
Mai	d 2 st h and 7 Is n treun		19a. Informant's Name/Relationship (7	ype, Print)	ì	g Address (Street and Numb	er or Rural F	Route Number, City	or Town, State, Zi	p Code)
	1 and Healt em 2	- 10	20a. Method of Disposition	er (1014e)	D. Place of Dispo	westmeath sition (Name of	De Lo	1112EL M	D 2070 Location - City or T	
Baltimore,	ages int of t: If It		1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cren	natory or other place)		1=30	,	
₽	artme ortan Injur		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		olumbia				uxsville,	MD
ä	Depa Impo eny Is		Youghn C	Greene	1.00	Name and Address of Facility of Career				11119
			23a. Part1. Enter the rise se, or comp shock, or heart failer. List only			er the mode of dying, such as	cardiac or r	espiratory arrest,	VIOLE, POCE	Approximate Interval Between
	Physician		Immediate Cause (Finaf disease or condition	Sansis						Onset and Death
	/Medical		resulting in death)	Due to (or as a cons						
ı	Examiner		Sequentially list conditions,	b. Congestiv.		rt Failure				
	pe iis	lne	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for as a cons	sequence of):					
	and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):					
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89	g phy as the	edical		u						
ŏ	eath certif attending for use as	2	230. Was decedent pregnant	23c. ff yes, outcome of pred 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy			23d. Date of deliv	төгү
P.O. Box	The law requires that the death cert site has been signed by the attendin page 2 should be detached for use	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Other (specify)			Month	Day Year
<u>Ч</u>	res that the de signed by the a be detached f	Phy	9 Unknown							
JS,	signer I be d	þ	Part II. Other significant conditions of		resulting in the ur	iderlying cause given in Part I	I.			the cause of death?
Š	w require been sign	Completed by		(00				-	7	bably 4 Unknown
ခိုင	hes by	mp	meumonia					24a. Was an autopsy performad?	prior to co	opsy findings avaitable empletion of cause of
Vital Records,	n: Tr ficete or, par		25. Was case referred to medical					1□ Yes 2 7 N	lo 1 Yes	2□ No
5	Physician: The la ir this certificete he aral director, page 2	To Be	examiner?	Hospital: 1 Minoation 2	☐ ER/Outpatien			Check only one)	6 □Other (Speci	
ō	g Phy er thi		27. Manner of Death	28a. Date of fnjury (Month, Day Year,		28c. Injury at Work?		I. Describe how in		'Y/
<u>ö</u>	tending I leath. tor: After the funer	atlo	1 Naturat 5 ☐ Pending investigation) Injury	M 1 Yes 2	No			
Division of	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pface of Injury - Albuilding, etc. (Spe	t home, farm, stre	eet, factory, office	28f	Location (Street a	and Number or Rur	al Route Number,
	urs af									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best of my kiner: On the basis of exam and manner stated.	nowledge, death ination and/or inv	occurred at the time, date an estigation, in my opinion, dea	nd place, and ath occurred	I due to the cause(at the time, date a	s) and manner as a nd ptace, and due t	stated. o the cause(s)
	o the	Med	29b. Signature and title of certifier	and mariner stated.		29c. License number		29d. D	ate signed (Month,	Day, Year)
	r s r ō		· Bon 1	Yard.	MD	P1854	360	NIM	ou her 7	4,2006
	A Y		30. Name and address of person who co	ompleted cause of death (I	tem 23a) (Type, I			1000	WILDER Z	7 16006
1	U		Amish Gandhi	22 Sou	th Gr.	une Street	Ba	eto Mi	21201	
37	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Sig		AP 0				
A.	Registr	ar	DEC 0 4 201	16 Mayer	J. ADM	A COLOR				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? 🛭 38442 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Joanna Whitney Weigman December 2006 5:30 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 607 Biscay Avenue Baltimore Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Min. | March 25,1931 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 213 28 7406 75 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State r then "natural", or items 23a or 28e-f show the Medical Expressions the notified at 10d. Inside City Limits Maryland Anne Arundel Baltimore 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 607 Biscay Avenue U.S. 21225 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 A Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 1 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 is marked other then Elementary/Secondary (0-12) 2 College (1-4or 5+) Lion Brothers Executive Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Christian Constance Whitney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray Davidson / Son 207 - 7th Avenue Baltimore, Maryland 21225 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Department of important: if eny injury or once. Lorraine Park Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 12/5/2006 21. Si vature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 ramerou death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part T. Enter the disease of complications that caused the death. shock, or heart failure. List only one cause on each line. 23a. Part f. Enter the disease. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ebyo **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that iniliated events resulting in death) Last Due to (or as a consequence of). Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, oulcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal de: 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ፩ 1 🗌 Yes 2 1No 3 Probably 4 Unknown this certificate has been si al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No of Vital 1 ☐ Yes 2 1 No : After this certifical funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only ope) examiner' Hospital: ٩ 1 ☐ Yes 2 No 1 Inpalient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 27. Manger of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Atternars after death.

Arai Director: After any the for Division 1 Natural 5 Pending Injury 2 Accident investigation М 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MT (0) who completed cause of death (Jtem 23a) (Type, Print) 30. Name and address of person 0 20 40 E. 32. Registrar's Signature GOSALL 31. Date filed (Month, Day, Year) State 04

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Registrar

			For State Registrer	State of Man	yland / Depa		lealth and N	Mental Hygi		38443
	Physic /Medi			irginia	Workman			2. Date of Death Month Novembe	r 28 2006	
	Funeral	ner	4a. Facility Name (If not institution, give Mariner Health (5. Social Security Number 6. Security Number 10. Security Number	of North Ar	runde1 in yrs. last birthday) 89 Yrs.		Burnie If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept. I	Anne Ar	
	Director works 1-1 show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar	10	Oc. City, Town or Lo			Sept. 11	1, 191 ₁ we	St Virginia 10d. Inside City Limits 1 □ Yes 2 ☑ No
	th with the 23a or 28a ust be notif	ai Direc	10e. Street and Number 313 Hospital Di	rive		10f. Zip Code 21(061	10	Og. Citizen of What Co	ountry?
9800	d within 72 hours after death with the Maryland liene. r than "nature!", or items 23a or 28a-1 show the Moolical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ ②Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify: Wh	encan Indian, te, etc. nite
Maryland 21215-0036	d within giene. ir then	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired employe	during most of work I)	ing	6b. Kind of Business Hair Sa	,
ryland	should be filed ind Mental Hygi i marked other umatic avant, II	To Be (17. Father's Name (<i>First, Middle, Last</i>) Jacob 19a. Informant's Name/Relationship (<i>Ty</i>	Lightner	10h Maili	Address (Street	Flor	e (First, Middle, M		7.0.41
	1 and 2 Health a sm 27 is		Sherman M. Light:	ner / Nephe	ew 915 I	Lance Ave	nue Bal	timore,	Maryland 2 Coc. Location - City or	21221
Baltimore,	permit. Pages Department of important: if it any injury or o	Ī	1 MBurial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	\	Green Hi	11 Cemete Name and Addres	ry 12/4	once Fune	onterey, V eral Servi imore. Mar	
	Cate be executed /Medical Examiner and the burial-transit	dical Examiner	23a Part 1. Enter the disease, of complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Lany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	er the mode of dyin	g, such as cardiac (or respiratory arre	st,	Approximate Interval Between Deset and Death
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Vital Records, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions cor	ntributing to death but n	ot resulting in the ur	nderlying cause give	en in Part I.	23e. Did toba		obably 4 Unknown
ital Re		Be Completed	25. Was case referred to medical	NS 11/11			26. Place of Daut	autopsy	ed? prior to death?	completion of cause of
ō	문 등 등	Certification: To E	27. Mann Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 Wursing Ho	me 5 ☐ Residen 28d. Describe how	nce 6	cify)
DIX	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 Homicide determined	28e. Place of Injury building, etc. (S	Specify)			City or Town,		
	To the Ho. within 24 h To the Fur completely	Medical	(Check only 2 Medical Examir one) 29b. Signature and title of certifier 30. Name and address of person who og	and manner stated	amination and/or inv	29c. License	oinion, death occurr	ed at the time, dat	de and place, and due	to the cause(s)
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	l, Gla	Birule.	lud, 20	06/	(/	

DHMH 17 Rev 1/2001

ORIGINAL

П			1. Decedent's Name (First, Middle, La	ist)				- "	2	2. Date of Dea		V	3. Time of De	eath
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	Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town	, or Locatio	n of Death		4c. County	of Death		-
		á	10514 GREEN MI	OUNTAIN	CIRC	CLE	cour	-			HOW			
	Funeral		5. Social Security Number 6. S	Sex 7. Ag 1 M 2 □ F		last birthday) Yrs.	If Under 1 Year Months Day		Min.	B. Date of Birt (Month, Day	y, Year)	9. Birth	place (State or F	oreign
	Director		410 · 18 · 5813 Usual Residence of Decedent		88	IIS.				11.01.1	918		1N	
	land	ŀ	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1.	10d. Inside City I	Limits
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	ith the Marylan or 28a-f show e notified at	Director	10e. Street and Number		0000	21110111	10f. Zip Code	9			10g. Citizen of \	What Cou	ntry?	
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	deat ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.1	Was Decedent o	f Hispanic	Origin? (Speci	ify Yes or No-		ce - Americ	ean Indian,	
2	or it		1 Never Married 2 Married	1 Mayes 2 □ I If Yes, Give	Vo		1 □ Yes 2 🐼 N			,,	Specify			
Ś	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:		1 40- P	44-11-1-10-			1		DUA		
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2	2 should be filed withi and Mental Hygiene. Is marked other than aumatic event, the M	Be C	17. Father's Name (First, Middle, Last				, , ,	18. Mo	ther's Name (Maiden Surnan		1 301100	
5	lid be lental ked o	일	EDWARD YOUNG					LEE	medo	UGLE				
3	should and Men marke umaric	-	19a. Informant's Name/Relationship	Type. Print)		19b. Mailir	ng Address (Stre				er, City or Town,	State, Zip	Code)	
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ט	ges 1 and t of Health If Item 27 or other tr		20a. Method of Disposition	Demoual from State	20b. F	lace of Dispo	sition (Name of natory or other p		Da	te	20c. Location -	City or To	own, State	
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	nplications that caused one cause on each li	the deat ne.	h. Do not ent	er the mode of d	lying, such	as cardiac or	respiratory ar	rest,		Approximate Interval Between	en
Į	Physician		Immediate Cause (Final disease or condition	a Me	tast	ratio	- Pr	osta	ete	Cana	cer		Onset and Dea	C S
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):	^						16.	
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	led lisit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	derice oi).								
	icate be executed physician and s the burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of):						-		
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	w requires that the d been signed by the should be detached	Physic	9 ☐ Unknown	9∐Unknown										
- 0	as tha	by F	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	nderlying cause	given in Pa	rt I.	23e. Did to	bacco use cont	ribute to t	he cause of dea	ith?
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	Ing P		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry y Ye <i>ar</i>)	28b. Time of Injury	l v			Bd. Describe h	now injury occur	red		
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	or A after Direct in by	Certification:	4 ☐ Homicide determined	28e. Place of inj building, et	c. (Specif	y)	eet, ractory, one	e	28	City or Tow	Street and Numb n, State)	er or Hura	al Houte Numbe	ır,
-	pital ours a eral l		29a, Certifier 1 CertifyIng Pl	hysician: To the best	of my kno	wledge deat	n occurred at the	time date	and place ar	ad due to the	causa(s) and m	anner ac c	tatad	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only one)	miner: On the basis o and manner st	f examina	ition and/or in	vestigation, in m	y opinion,	death occurred	d at the time,	date and place,	and due t	o the cause(s)	
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	Registr													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. Reg. No. 2 U U () 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 29, 2006 John V. Zellers 1:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State of Month) | New Jersey | New Jersey | New Jersey | Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1X M 2□ F Yrs. 139-24-5899 75 Director Usual Residence of Decedent NJ State r 28a-f show notified at 10c. City Town or Location Gillette MOTT S 10d. Inside City Limits 1XTYes 2 □ No Director Maryland Montgomery Darnestown-10e. Street and Number 60 Sunrise Drive 10f. Zip Code 10g. Citizen of What Country? 07933 filed within 72 hours after death with Hygiene. 27 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 15645 Haddonfield Way 20878 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 X Yes 2 No 1952 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemical Engineer Chemical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental H Be Alfred Zellers Anna Demmer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s f Health a Linda Labarge /Daughter 15645 Haddonfield Way, Darnestown, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place)
Pleasant Grove 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any injury or ott December 1 Burial 2 □ Cremation 3 □ Removal from State 2006 4 ☐ Donation 5 ☐ Other (Specify) Long Valley, New Jersey Union Cemetery 21. Signature of Funeral Service Licences Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. angletter M01305 ans 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final luvuay Physician Day disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, Examiner attending physician and for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has the lirector, page 2 s autopsy 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specity) 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) UNA November 30, 2006

24

31. Date filed (Month, Day, Year)

ALAN CHANATE

32. Registrar's Signature

DEC 0 4 2006

30. Name and address of person who completed cause of death (Item 23a) (Type (Print)

s signature

DHMH 17 Rev 1/2001

State Registrar

		State Registrar	Department of Health and Certificate of Death		g. No.	38446
Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3.	Time of Death G:70 p M
/Medic		Lonald Hnderson 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death	1-2-1
Examin	er	STAGNES Hospital	BALTIMOR		N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	Months Davs Hours Mi	S. 8. Date of Birth (Month, Day,	0. District	(State or Foreign
Director		219-28-8009 15M 2LF 76 Usual Residence of Decedent	Yrs.	Month, Day,	,1930	UNK
within 72 hours after deeth with the Maryland ene. Then "natural" or items 23a or 28a-f ehow the Madical Examinar must be notified at		111	own or Location			nside City Limits
point. Tages the part of the p	Funeral Director	Md N/A Salt	10f. Zip Code	10	g. Citizen of What Country?	195 2 100
3a or	ă	1525 Adams View Rd	21228	10	USA	
ma 2	nera	12 Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No-	14. Race - American In Black, White, etc.	dian,
or its	y Fu	Armed Forces? Never Married 2 Married 1 Yes 2 No If Yes, Give	1 Yes 2 No Specify:	rto i noan, etc.,	Specify:	
al Ex	ed by	3 Wildowed 4 Divorced Year or Dates:	6a. Decedent's Usual Occupation	1	6b. Kind of Business/Industry	<u>e</u>
n "n Madic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of w life. DO NOT use retired)	orking		,
- 4	EOC	UNK College (1-401 34)	UNK		UNK	
d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's N	ame (First, Middle, M	laiden Sumame)	
ie marked other then aumatic event, the M	ဥ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or I	Byral Boute Number	City or Town State Zin Code	۵)
27 ie r trau		Dele Sangodey	. ^ -	Saltimore	Md 2121	2
othe	Ì	20a, Method of Disposition 20b. Plac	e of Disposition (Name of etery, crematory or other place)	Date 2	Oc. Location - City or Town, S	State
ry or		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	13	17/06/1	Dundalk 1	ld.
Imports eny inju ence.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility (Charman	-Harris Funer	al Home
2 2 9		Jerry Francis	5240 Reisterston			1215
		23a. Part. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. Immediate Cause (Finat			Ons	rval Between et and Death
ysician Vledical		disease or condition resulting in death) Due to (or as a consequent	edin INFARTI	'0N	U	ANDW.
miner						
## ## ## ## ## ## ## ## ## ## ## ## ##	iner	if any leading to immediate Due to (or as a consequent	ice of):			
icien and burial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequen	ice of);			
	20	L _d				
ettending phys for use as the	Medic					
or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal de	ath 3 Ectopic pregnancy		23d. Date of delivery Month Day	Year
ched fo	Physician/Medic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death	h 5 Other (specify)		Jay	rou
e deta	by Ph	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the car	use of death?
d bluc	ted to	HYPER KALEM	· · · · · · · · · · · · · · · · · · ·		s 2 No 3 Probably	<u> </u>
es de es sh	Completed	CHRONIC RA	ENAL INSUFFICE	autopsy	prior to complet	indings available ion of cause of
cate r				perform 1 ☐ Yes 2	ed? death?	No
recto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ER		eath (Check only one	nce 6 Other (Specify)	
eral d	n: To	27. Manner of Death 28a. Date of Injury 28	b. Time of Injury at Work?	28d. Describe how		
n: An	atlo	2 Accident investigation	M 1 Yes 2 No			
Directo in by t	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Str. City or Town,	eet and Number or Rural Rou State)	ite Number.
filled		29a. Certifier 1 Certifying Physician: To the best of my knowle	doe, death occurred at the time, date and pla	ce and due to the ca	use(s) and manner as stated	
To the Funerel Director: After this certilicate hes been signed by the ettending phys completely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death oc	curred at the time, da	te and place, and due to the	cause(s)
To the Funeral Director: A completely filled in by the fu	Ĭ	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day,	Year)
		· Chile (in)	DOOSI8 Ga) (Type, Print) Moness HOSPITM	65 /	VOVEMBER	2006
L L		30. Name and address of person who completed cause of death (Item 23	Ba) (Type, Print)	BAZ	17 mire	no
)						
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	9	- 0,70,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signatur DEC 0 5 2006	Sparks (Cost 17)			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** Month Day banese 0635 AM 2 2006 /Medical 4a. Facility Name (If not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Year 1**)**X M 2□ F Usual Residence of Decedent Director with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other than any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits New Jerses 1 ☑Yes 2 ☐ No Ocean Directo Jackson 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Nes 2 No 1455 If Yes, Give Year or Dates: 195 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No white ρ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Crown, Elementary/Secondary (0-12) College (1-4or 5+) Distributer 12th NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albanese on cetta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ridge WIFE 11 Park Jackson Albanese -Way NJ. marie 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cemation 3 Removal from State Doyle NJ. Voterans 12-6-06 Arneutown 4 □ Donation / 5 Other (Specify) 21. Signature of Juneral Service/Licensi 270 FredHILTON The disease, or complications that caused the death. Do not enter the bode of dying, such as cardiac or respiratory arrest, sart failure. List only one cause on each line. Home 23a. Party. Enter shock, of h Approximate Interval Between Onset and Death Immediate Cause (Final disease or bandition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death 9☐ Unknown Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed Congestive heart failure 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No autopsy performed? Yes 2 \(\subseteq No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification:

Records, Division or Vital To the Hospital or Attending Physiclan: death. within 24 hours after death To the Funeral Director:

27. Manner of Death 1 ☑ Natural

2 Accident 3 ☐ Suicide 4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier

Medical

State Registrar 5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

and manner stated.

1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

AUENUZ

000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

01

06

MD 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVID HAGER 31. Date filed (Month, Day, Year)

UEC 0.5 2006

egistrar's Signature

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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene	2	0	0	6	
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			1 - For State Registrar	State of Marylar	nd / Depa <i>Cer</i>	artment of Healt tificate of Dea	th and Me	ntal Hygie		6 38448
y	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Las TAMM I 4a. Facility Name (If not institution, give BON SECOU	BRE	WE	4b. City, Town, or Locati	N	Date of Death Month OVEMBEI	Day Yea 7 18 200 4c. County of De	6 7:29 AM
Ī	Funeral Director		5. Social Security Number unk 6. S			,	nder 24 Hrs. 8	Date of Birth (Month, Day, Yeept 25,	9. B	irthplace (State or Foreign Country) UNK
	the Maryland 28a-f ehow notified at	Director	Usual Residence of Decedent 10a. StateUnk 10b. County 10e. Street and Number	unk 10c. Cit	ty, Town or Lo	cation		unk 10a.	unk	10d. Inside City Limits unk₁ □ Yes 2 □ No
36	d within 72 hours after death with the Maryland jiene. r than "naturel", or lieme 23a or 28a-f ehow the Madical Examiner must be notified at	by Funeral Di	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	.S. 13. V	Vas Decedent of Hispanic Yes, specify Cuban, Mex	o Origin? (Speci kican, Puerto Ri		14. Race - An Black, Wh	USA nerican Indian,
Maryland 21215-0036	filed within 72 hou Hygiene. other than "natural ent, the Madical Er	Completed b	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) unk	ucation	(Give)	ent's Usual Occupation kind of work done during to O NOT use retired)	most of working	unk 16b	. Kind of Busines	
магујапо	2 should be and Mental is marked of sumatic eve	To Be	17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (7)	• •		g Address (Street and Nu	mber or Rural F		ty or Town, State,	
Baltimore, n	Pages 1 an ment of Heel ant: If Item 2 ury or other		Bon Secours Hospi 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State in state	Place of Dispos emetery, crem	W. Baltimor	ce Stree	-	nore, MD . Location - City o	21223 r Town, State
Da	permit. Pag Department Important: any Injury o		21. Signatur, Fundal Service Licent II ald S	lications that caused the death	Ba	Name and Address of Fa ate Anatomy ltimore, MD or the mode of dying, such	21201		altimore	Street
9,0078	Physician physician and physician and physician and physician and the prival-transit the prival-transit physician and physician	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. SEP Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): uence of): G	EMIA RENAL DEPE	FAI N DEI	LURE	-	Interval Between Onset and Death
O. BOX 6	I the death certifi by the attending I ached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Preg <i>n</i> ant at time of de 9 □ Unknown	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
corus, r	w requires that s been signed t should be det	þ	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the und	derlying cause given in Pa	art I.	23e. Did tobacc	_	o the cause of death?
אוואו הפני	en: The law tificete has b tor, page 2 si	e Completed	25. Was case referred to medical			26 DI	ace of Death (C	24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of
	To the Hospital or Attending Physicien: The law Within 24 hours after death: Within 24 hours after death: You the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2.5.	Certification; To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of fnjury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA Other: 4 D	Nursing Home 28d		6 □Other (Sperifury occurred	ecify)
Division	pepital or At hours after of ineral Direct y filled in by		4 Homicide determined	building, etc. (Specify	wladge death	occurred at the time, date	28f.	City or Town, Sta	ate)	ural Route Number,
•	To the Hc within 24 To the Fu completel	Medical	29b. Signature and title of certifier Columbia	ner: On the basis of examinat and manner stated. R. C. J.	ion and/or inve	29c. License numbe	death occurred a	at the time, date a	and place, and du	e to the cause(s)
	Sta	te	30. Name and address of person who c	ompleted cause of death (Illem R L) 32 Registrar's Signat	2 1	rint) M. D.	30N	SEC	VEMBE, OURS	Hospita

State of Maryland / Department of Health and Mental Hygiene 0 0 6 Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dey Year 27-2006 **Physician** 6:40 PM Aloysius Herbert /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street end number) Examiner Solomons alver Asbury-Circle Solomons If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1⊠ M 2□ F 1920 Rhode Island 035-09-9803 Aug 5, Director Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Manyland nent of Health end Mental Hyglene.
ant: if item 27 is marked other than "natural", or items 23e or 28e-f show unt: if item 27 is marked other than "natural", or other transmit be notified at uny or other transmit be notified at uny or other transmit be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐ Yes 2 ☑ No MD Calvert Completed by Funeral Director Solomons 10g, Citizen of What Country? 10f. Zip Code 10e. Street end Number 531 Aldergate Ct Box 508 20688 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white Year or Detes: 145-65 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) education/U.S. Navy professor/officer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Kathryn Dunn Herbert Aloysius Behre 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 531 Aldergate Ct Box 508 Solomons, MD 20688 Alice Behre/spouse 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: if its any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Wade ctor 21201 Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) 4 years /Medical (erebrovas aulan Examiner Due to (or as a consequence of) Examiner sicien end bunal-transit Hospital or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medicai Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown arkmsonism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 21X No 1 ☐ Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Medical Certification: To 1 Yes 2 No this 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? After 5 Pending 1 ☐ Yes 2 ☐ No ours efter death.

werai Director: Af investigetion 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide within 24 hours e To the Funeral C completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature, and title of certifier 25 156 281 06 rances (Sensett M.D. 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Trueman Road, Lusby, Md. 20657 11845 harles Bennett M.P. 31. Dete filed (Month, Day, Year) 32//Registrar's Signature State e less Registrar DEC 0 5 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:00 P M Paul Douglas Black November 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Irvington Baltimore N/A 8. Date of Birth (Month, Day, Year)
Dec 2, 1 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Months Days Hours **№** M 2 🗆 F 58 165-40-1241 Director 1947 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner πust be notified at 1 Yes 2 No Director Baltimore Maryland N/A 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 22 South Athol Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ... withit ... wental Hygiene. a. 27 Is marked other than "? r traumatic ever-Elementary/Secondary (0-12) College (1-4or 5+) Teaching Academics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Black Alice McLaughlin ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Allenberry Circle Pittsburgh, Georgia Deemer, Sister Pа. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of I Important: If Its any injury or of once. 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Metro Crematory 11 12/02/06 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregory ²Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Physician/Medical Examine physician and the burial-transit attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No performed' 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 within 24 hours a To the Funeral L Hospital 1 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only the

P.O. Box 68760 Division or Vital Records.

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

DHMH 17 Rev 1/2001

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

06-09182

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Jeremy Jacob Bo		Sta I- For State	te of Marylar	•	artment of rtificate of		nd Ment	al Hy	_		000	
Physicia		Registrar 1. Decedent's Name (First, Middle,	Last)		-			1:	2. Date of De	Reg. No.	. U U	3. Time of Death
Medical Exami		Jeremy J. Buck	ζ						Month December	er 2, 2006	Year	2325 hrs
part -		4a. Facility Name (if not institution, Harbor Hospital	give street and num	nber)	4	b. City, Town, Baltimore		f Death		1	ty of Death	e City
Funeral		Social Security Number 6	. Sex 7	7. Age (In yrs I	ast birthday)	If Under 1 Y	ear If Unde	r 24Hrs.	8. Date of B			hplace (State or
Director		218-94-2198	1XM 2 F	29	Yrs	Months D	ays Hours	Min.	May 4	, 1977	Foreig Cou	n untry) Maryland
	ŀ	Usual Residence of Decedent										
w any		10a. State 10b. County			Town or Locati	on						10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show d at once.	į	Maryland Baltimo	re City	Br	ooklyn	10f. Zip Code			- 1	10g. Citizen of	What Cour	
ith the Maryland 23a or 28a-f sho notified at once.	ire	3904 Brooklyn Av	7.0			21225	-		1	United		
with the same se noti	Funeral Director	11. Marital Status	12. Was Dece			s Decedent of			cify Yes or N	o- 14. Ra	ace - Ameri	can Indian, Black,
death or iten	nne	1 X Never Married 2 Mar	ried Armed For	ces?	If Y	es, specify Cut	oan, Mexican,	Puerto F	Rican, etc.)	W	hite, etc.	
s after	J.		ced If Yes, Give Year or Dates:	1.4.19		Yes 2 X		1-1-5		Specif	. 7111	ite
hour hatu	ted	15. Decedent's Education (Specific Elementary/Secondary (0-12)	College (1-		16a. Deceden during me	rs Usual Occu ost of working l				16b. Kind of	Business/II	ndustry
336 thin 72 re than	Completed	10	, somege (,	Carpe	nter				Const	ructi	on
21215-0036 Auld be filed within 7 Mental Hygiene marked other than c event, the Medica		17 Father's Name (First, Middle, L	ast)		-			,		Maiden Surnar	me)	
121 d be fi fental narked	o Be										Cours State	Zio Codo)
MD 2 id 2 shoul ilth and N in 27 is in aumatic	-1	Marian L. Ciervo		_	4					re, MD		
e, N l and 2 Health item 7	1	20a. Method of Disposition		20b.	Place of Disposi crematory or oth	tion (Name of	cemetery.		Date	20c. Locatio		
altimore, MD 21215-0036 mit Pages I and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygene portant: If iten 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at once		Burial 2 X Cremation 4 Donation 5 Other Spe		III Quale	tro Cre			Dec. 200		Caton	svill	e, Maryland
part mit	Ì	21. Signature of Funeral Service	ensee	-	22. N	ame and Addr	ess of Facility	Fur	oral l			
_ =====	8 9	23a. Part I Enter the disease, or co	<u></u>							Home, P		D 21061 Approximate Interval
Physician /Medical		failure. List only one cause or	n each line.			ie mode or dyn	ig, such as ce	il diac oi	respiratory ai	rest, shock, or	licart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Cardiac a									
Margaret .		Sequentially list conditions,	b Probable									
	nine.	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a c	consequence o	if):							
الله الله	Examiner	events resulting in death) Last	Due to (or as a c	consequence c	f):							
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of Vital Records, P.O. Box 6876(ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phy luneral director, page 2 should be detached for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th nt at time of de	oth _		3 Ectopic	pregnan	су	Month	D D	ay Year
30x death of	ysic	1 Yes 2 No 9 Unkn			5 Oth	ner (Specify)						
		Part II. Other significant conditio	ns contributing to	death but not r	esulting in the u	nderlying caus	e given in Pai	t I.				he cause of death?
S, P uires th	ed by		-				· · · · ·			STATE OF STREET	275	ably 4 Unknown
ord aw req nas bee	Completed								24a. Was			opsy findings available ompletion of cause of
Rec The I ficate ;	5						- 12		1 🗸 Yes		1 🗸 Ye	s 2 No
Division of Vital Records, P.O. rat or Attending Physician: The law requires that it is after cleath. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Be	25. Was case referred to medical examiner?	Hospital: 1 In	patient 2 🗸	ER/Outpatient		Other		Home 5	Residence 6	Other	
of V ng Phy offer th	2	1 ✓ Yes 2 No 27. Manner of Death	28a. Date o	f Injury Day,Year)	28b Time of Ir	njury 28c Ir	njury at Work	? 2	28d Describe	how injury occi	urred	
Sion kttendii death. ctor: A	atio	1 X Natural 5 Pendir 2 Accident Investi	ng			1	Yes 2	No				
Division of ' pital or Attending Ph ours after death. reral Director: After t filled in by the funeral	Certification:	3 Suicide 6 X Could determ	not be	of Injury - At h	ome, farm, stree	t, factory, offic	e building, etc	2	28f. Location or Town,		mber or Rur	al Route Number, City
<u></u> ≥ <u>•</u> = [29a Certifier Cartifulas Phys	sician: To the best	of my knowled	ge death occur	red at the time	date and plac	ce and d	lue to the cau	use/s) and mann	ner as start	ed ed
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Exam	iner:On the basis of	examination a								
To To	Me	29b. Signature and title of certifier	and manner sta	ated.		29c Lice	nse number			29d Date sig	gned (Mon	th, Day, Year)
		hing his,	me			0.0	C.M.E.			Decembe	er 3, 200	6
1		30. Name and address of person w				t Daltima-	MD 242	21				
Ψ			t Medical Exam		Penn Stree	t, Baltimore	e, IVID 2120	JI				
St	ate	31. Date filed (Month Day, Year)	2006 32 Reg	istrar's Signati	F GOA							

			For State Registrar	State of Maryland		rtment of l		d Mental Hy	giene Reg. No	ZUUb	38452
	Physicia	an	1. Decedent's Name (First, Middle, Last) SAMMY LEE	BURNI				2. Date of D	eath	y A Year	3. Time of Death P
	/Medio	al		treet and number)		4b. City, Town,	or Location of De			County of Death	
	Funeral		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 H		irth ay, Year)	9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent	10				120	4 19	35 3,6	10d. Inside City Limits
	Marylar a-f ehow	ctor	10a. State 10b. County N-A		Hown or Loc						1 Yes 2 No
	h with the	ai Dire	10e. Street and Nimber MOSNE	R St.		10f. Zip Code 2/2	17		10g. Cit	S, A	intry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelih and Mental Hyglene. Depertment of Heelih and Mental Hyglene important: if Item 27 ie marked other then "naturel", or Items 23e or 28e-f ehow apply injury or other treumatic event, the Medical Examinar minister notified at once.	by Funeral Director	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forcas? 1 □ Yes 2 2 100 If Yes, Give Year or Dates:	lf If	/as Decedent of Yes, specify Cut	oan, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Amer Black, White Specify:	
Maryland 21215-0036	within 72 ho iene. 'then "natur	Completed	15. Decedent's Educ (Specify only highest grade		16a. Decedi (Give k	ent's Usual Occu kind of work done O NOT use retire	pation during most of v	vorking CIEK	16b. K	ind of SQsiness/1	ndustry EA
/land	should be filed and Mental Hyg marked othe umatic event,	To Be C	17 Famer's Name (First, Middle, Last) POPER BUK	Ris			18. Morher's	Name (First, Middle ALE	Maiden HA	Surriame)	
	and 2 sho eelth and I m 27 ie ma		19a, Informant/s/Name/Relationship (Ty	pe, Print)	19b. Mailing	Address (Stre	t and Number of	Aurai Agrie Nym	ber, City of	Fown, State, Z	2/7-
Baltimore,	Pages 1 a nent of Her int: If item iry or othe		20a. Method of Disposition → Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	l » Icha	ce of Dispos	ition (Name of atory or other pla	(A)	1-06	37W	OSCIONAL OF THE PROPERTY OF THE	on suna
Baltir	permit. P Depertme Importen any injur		21. SignarQre of Funeral Service Licens	Galmore	13	Name and Addr	ENTE	CEPH !	3.00 3.414	S.MI.	21202
	Pnysician		23a. Part 1. Inter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the death. the cause on each line.	Do not ente	r the mode of dy	ing, such as card	fiac or respiratory	arrest,		Approximate Interval Between Onset and Death Company
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequen		1					e manage
_	ed slt	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of).						
8760,	icate be executed physician end s the burial-transit	dicai Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):						
Box 6	ath certif ettending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	Ectopic pregnand Other (specify) _	·y			23d. Date of deliv Month	very Day Year
ds, P.O.	n requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions con	ntributing to death but not resulti	ing in the un	derlying cause gi	ven in Part I.	11		use contribute to	the cause of death?
Division of Vital Records,	The law rec ate has been page 2 shou	Completed						24a. Wa auto peri 1 🗆 Yes	s an opsy formed? 2 No	prior to codeath?	opsy findings available ompletion of cause of
/ita	iclan: ertific ector,	Be	25. Was case referred to medical examiner?	lospital:				eath (Check only	one)		
on of	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 Er	R/Outpatient 8b. Time of Injury	28c. Inju		Home 5 Res 28d. Describe			rfy)
Divisi	ii or Atten after deal Director: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office			(Street and		al Route Number,
	To the Hospital of within 24 hours aft To the Funeral Completely filled it	edical C		sician: To the best of my knowledge: On the basis of examination and manner stated.							
ì	To the Within To the compl	Me	29b. Signature and title of certifier	2			se number		29d. Dai	te signed (Month	Day, Year)
	4		30. Name and address of person who co	impleted cause of death (Item 2	?3a) (Type, F			,		1	
	Sta	te	31. Date filed (Month, Day, Year)	32. Restrar's Signatur	1 N 1	EUTAL	J 57 H	301-13	ALT	MONE	MO 21201
	Registr			2008	y A	make					

			For State Registrar	State of Marylan		artment of F		and Me		iene	200	16 38	1.53
ì	Physici	an	1. Decedent's Name (First, Middle, L.	ast)				2	2. Date of Dea Month	th		3. Time of	Death
	/Medi	cal	Jesse 4a. Facility Name (If not institution, gi	Olden		Bailey	-1		ecembe:				Рм
	Examir	ier	9310 Seabay Cour			4b. City, Town, o Edgemer		of Death			ounty of Do		
	Funeral			Sex 7. Age (In yrs.		If Under 1 Year Months Days		24 Hrs. 8	B. Date of Birth (Month, Day)	1	9. 6	Birthplace (State of	or Foreign
	Director		222-24-8493	1 □XM 2 □ F	65 Yrs.	Months Days	Hours	L L	ecember	8, 19		_{Country)} est Virgi	nia
	rland ow at		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside Ci	ity Limits
	a-f sh iffed a	tor	Maryland Baltin	nore E	dgemer	e						1 ☐ Yes	2 \ No
	or 28	Dire	10e. Street and Number			10f. Zip Code			1	0g. Citize	n of What	Country?	
	s 23a nust b	eral	9310 Seabay Court	_	0 140	2121					SA		
36	be filed within 72 hours after death with the Maryland ttal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married ② 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 🎇 No	IIspanic Orig an, Mexican Specify:	gin? (Speci n, Puerto Ri	ty Yes or No- can, etc.)		Black, W Becify: W		
9	2 hou latura	ted	15. Decedent's E	Education	16a. Deced	dent's Usual Occup	ation			16b. Kind	of Busine	ss/Industry	
218	ithin 7 ne. nan "r Med	Completed	(Specify only highest gi	College (1-4or 5+)		kind of work done of NOT use retired	during most d)	t of working	'	Con		++	
121	lled w Hygier ther th		11 years 17. Father's Name (First, Middle, Las	**	Carp	enter	10 Matha	wa Nama /	Final Ministra		struc	CION	
Maryland 21215-0036	2 should be filed vand Mental Hygie I is marked other is raumatic event, th	To Be	John Bailey	<i>y</i>					First, Middle, I Lllings		irname)		
ary	should and Men s marke umatic	F	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Street					own, State	e, Zip Code)	
	es 1 and 2 of Health a f item 27 is r other trai		Sheila Bailey	wife	4506	Goldern N	1eadow	v Driv	e, Per	ry Ha	all,	MD. 2112	:8
Baltimore,	Pages 1 ment of H ant: If itel ury or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec	Removal from State	emetery, crer	sition (Name of natory or other place Cremator i		Decemb 4, 20	ET			or Town, State City, MD).
Balt	permit. Page Department. Important: If any injury o		21. Signature of roth rall Service Lice	11	0109L 7	Name and Addresonnelly F 110 Solle	ss of Facility unera ers Pc	il Hom	ne Of D Road, D	unda. unda.	lk,P. lk,MD	A. 21222	
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the death y one cause on each line.								Approximate Interval Bet	ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Non Small		- CONG	GING	SER				Six Me	PNT HS
٩	Examiner			Due to (or as a consequ	uence of):								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequ	uence of):								
	ecutec ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С.									
8/60,	sate be executed hysician and the burial-transit	a E	resulting in deathy East	Due to (or as a consequ	uence of):								
28	fficate g phys	edical		_d.									
ROX	death certificate be executed e attending physician and d for use as the burial-transit	JW/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Fetal	ncy	Ectopic pregnancy				230	d. Date of c	delivery	
Б	the dea y the att ached fo	hysician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5	Other (specify)				;	Month	Day	rear
S,	w requires that the de been signed by the should be detached	by Pi	Part II. Other significant conditions	contributing to death but not resu	ılting in the ur	nderlying cause give	en in Part I.		23e. Did tob	acco use	contribute	to the cause of d	eath?
ecord	requires een sign nould be								1 № Ye	es 2 🔲 I	Vo 3□	Probably 4 □U	Jnknown
Š	e la has	ompleted						_	24a. Was ar autops perform	у	24b. Were prior to death	autopsy findings a to completion of ca ?	available ause of
VItal	sician: Th certificate rector, pag	Be Co	25. Was case referred to medical				26. Place	of Death (0	1□ Yes 2 Check only one	No No	1 🗆 Ye	es 2 No	
or <	G is ×	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	t 3□ DOA Othe			5 Reside]Other (S _I	pecify)	
	ng (fter		27 Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl			d. Describe ho	w injury o	ccurred		
UIVISION	vitend death ctor: ,	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	De 290 Place of injuny At hou	me farm stre		Yes 2 ☐ N		Location (St	root and A	lumbarar	Rural Route Num	bor
<u> </u>	al or Attending P s after death. al Director: After i ed in by the funera	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	,,,			City or Town	, State)	dinber or	nurai noute ivuiri	Der,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier Check only one) Certifying P	hysician: To the best of my know miner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the tin restigation, in my o	ne, date and pinion, deat	d place, and th occurred	d due to the ca at the time, da	ause(s) an	id manner ace, and d	as stated. lue to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier	7 / 1 / 1		29c. License				d. Date s	igned (Mo	nth, Day, Year)	
)	3		1 mte (a)	Losa MD		05	456	0	P	ECEN	SER	4 2006	
	4		30. Name and address of person who Teyws KPR.N.5 K	OSP. THE NOT	23a) (Type, 1		REET	Bris	TheRs	MAR	4 CAN	A 212	25
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 5 200	32. Registrar's Signat	ture Joseph	L.			~*				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38454 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11 2006 7:00p.M Olivia Bond 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Joseph Richey Hospice Inc. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 🗓 F 220-30-0958 91 04 19 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits YYYes 2 □ No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 U.S.A. 2109 Westwood Ave 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married

1 ☐ Yes 2 🔀 No

16a. Decedent's Usual Occupation

Domestic

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Specify.

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Willis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2807 Diamond Ridge Road, Windsor Mill,

11/25/06

22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md

(Give kind of work done during most of working life. DO NOT use retired)

Black

21215

16b. Kind of Business/Industry

Private

20c. Location - City or Town, State

Arbutus, Md

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with it. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2! any injury or other traumatic event, the Medical Examination.

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

Ş

Completed

Be P MD

3 Widowed 4 □ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

Linda Smith-Friend

21. Signature of Funeral Service Licensee

X□ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)

10th grade

20a. Method of Disposition

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

Unknown

na

the Maryland

sician and burial-transit Division or Vital Records, P.O. Box 68760 attending pl ed by the a

Examiner Be Completed by Physician/Medical Certification: To

Medical

State Registrar

the Hospital or Attending Physician: hin 24 hours after death.

the Funeral Director: After this certifica mpletely filled in by the funeral director, p within 24 hours a

Immediate Cause (Final disease or condition resulting in death)	a. Metostatic Colon Concer	Onset and Death
Toosiang in dodain)	Due to (or as a consequence of):	
Sequentially list conditions,	b	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live pith 21 legal death 31 lectonic pregnancy	ate of delivery Ionth Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use cor	ntribute to the cause of death?
	24a. Was an autopsy performed 1 Tyes 21 No	. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Dot	ther (Specify) HOSDICE
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No	
3 Suicide 6 Could not be determined		ber or Rural Route Number,
29a. Certifler (Check only one) 1 Certifying Ph 2 Medical Exar	nysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and magner stated.	nanner as stated. , and due to the cause(s)
29b. Signature and title of confifer	MULT MD 29c. License number 29d. Date signe DEC	ed (Month, Day, Year)
30. Name and address of person who	completed vause of death (Item 23a) (Tuge, Print) CEY GOO (ATON AVE BUTIMONE M.	D 21229
31. Date filed (Month, Day, Year)	32. Registrar's Signature	
DEC 0 5 2	1006 persons he popular	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

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1. Dece		e (First, Middle	e, Last)							2. Date		J. NO. 5	000	3. Time of Death
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Si	nai	Hospi	tal o	+ Bau	imore		Baltin	nore	City					
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	/Medic		4a. Facility Name (If not institution, g				Brown	Location of Death	1.1	4c. Count		3:15a. ^M
	Examin	er	Future Care N		·			.lstown				
	Funeral			. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Ltimo 9. Birthp	lace (State or Foreign
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	3a or	Ö	5412 Old Court	Road				1133		-	S.A.	
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ក	n 72 h "nat	Completed	15. Decedent's (Specify only highest of	grade completed)		16a. Deced	ent's Usual Occupa kind of work done of ONOT use retired	ation Juring most of work)	ing	16b. Kind of B	usiness/Ind	ustry
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<u> </u>	Hygor Other ent, t	Be C	17. Father's Name (First, Middle, La			CIVII	. Delvic	18. Mother's Name				over iment
land	uld be denta rked ric ev	To B	Edward Brown					Mattie	Berry			
a	should have	-	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street a	and Number or Run	al Route Number	; City or Town	State, Zip	Code) 21244
Ξ. 	and 2 ealth n 27 i		Virginia Arnwi	ne-frie				Terrace	Unit	#7, B	alto	Md
ore	Jes 1 t of H if iter		20a. Method of Disposition 1 ☐ Cremation 3	☐Removal from	CALL C	emetery, crem	sition (Name of natory or other place	e) ¦		20c. Location	•	
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<u> </u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparament of Health and Mental Hygiene. Important: If them 27 is marked other than "naturaly" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.	/	21. Signature of Funeral Service Lie	ensee	MIL		Name and Address					
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			23a. F rt1. Enter the disease, or co hock, or heart failure. List on Imm diate Cause (Final	ly one cause on e	ch line.	. Do not ente	The mode of dying					Approximate Interval Between Onset and Death
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	ne Ho n 24 h ne Fui	Medical	(Check only 2 Medical Ex	aminer: On the ba and mann	asis of examinat	tion and/or inv	estigation, in my op	pinion, death occurr	red at the time, da	ate and place,	and due to	the cause(s)
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			Charles	More	IM	D	D3	5730	1	NOV. 2	8,20	06
	5		30. Name and address of person wh	o completed cause	e of death (Item	23a) (Type, F	rint)	1 /	14.	1/	1	06 Md21128
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	Dhusisi	_	1. Decedent's Name (First, Middle,	Last)							2. Date of De. Month DEC	ath Day 03	Yeer		of Death	
1 62	Physici /Medic	al	EDSEL WAYNE BISHOP								DEC		2006) M	
	Examin	er	4a. Facility Name (If not institution,		ber)		4b. City, T			of Death		4c. C	County of Dea	ith		
		Wigner.	5. Social Security Number		7. Age (In yrs.	last hirthday)	BALT I If Under 1		If Under	24 Hrs.	8. Date of Birt	th	9. Bi	thplace (State	or Foreian	
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ē,	of Health Item 27		20a. Method of Disposition		1 6	Place of Dispo	sition (Name	e of	e)		Date	20c. Loc	ation - City o	Town, State		
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	10		30. Name and address of person	who completed caus	e of death (Iter	m 23a) (Type.	Print)				an)	//	700			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Victor Bell 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Futurecare - Canton Baltimore City If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 NY 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Min. Days Months Hours 93 134-60-2727 Director 02/09/1913 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 √2 Yes 2 □ No Director MD Baltimore City 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21224 USA 1300 S. Ellwood Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) teacher school system 12 should be filed w th and Mental Hygiel 7 Is marked other tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 ment of Health a ant: If Item 27 is 10 N. Calvert Street; Baltimore, MD 21202 Alice Bellamy / Guardian or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Zion Cemetery 12/07/2006 Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wylie Funeral Home, P.A. tones 638 N. Gilmor Street; Baltimore, MD 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Huse disease or condition resulting in death) /Medical Examiner consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 1 Yes 2 1 N To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 Tyes 2**111**0 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hudson St. Suite A. .16 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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			For State Registrar	Otate 0	i waiyian		tificate d			nomarry	Reg. No. 2	000	00150
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			JOHNS HOPKINS					ALTH	mole	25		N/	
	Funeral Director		5. Social Security Number 212-42-2945 Usual Residence of Decedent	6. Sex 1 ⊠ M 2 □ F	7. Age (In yrs. 75	last birthday) Yrs.	If Under 1 Your Months Da	ays Hour	der 24 Hrs. rs Min.	8. Date of Bir (Month, Da 0ct. 2		Co.	hplace (State or Foreign untry) "Many
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	3a or 28a	I Director	10e. Street and Number 401 Valley Cou	rt Rd.			10f. Zip Cod	de 210	93		10g. Citizen	of What Co USA	untry?
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Baltimore,	permit. Pages 'Department of H Important: If Ite any Injury or of once.		21. Signature of Funeral Service	5x			1050	Tows York	on Fu Rd.	neral H Towson,	Md. 21	ic. 204	
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0		1: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time of		Injury at Work?	Nursing H	ome 5 ☐ Res 28d. Describe			cify)
ion	Attending F r death. ector: After by the funer	atior	1 Natural 5 ☐ Pendin 2 ☐ Accident investi	gation	th, Day Year)	Injury		1 ☐ Yes 2	No				
Division	al or Atte s after des al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could determ	ined Zoe. Place	e of injury - At he ing, etc. <i>(Speci</i>	ome, farm, str fy)	eet, factory, of	fice		28f. Location City or To	(Street and Nu wn, State)	mber or Ru	ıral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the Examiner: On the b and man	e best of my kno asis of examina ner stated.	owledge, deat ation and/or in	vestigation, in	my opinion,	death occu	, and due to the irred at the time	cause(s) and , date and pla	manner as ce, and due	stated. to the cause(s)
	To th To th	M	29b. Signature and title of certifie	01.1				cense numb			29d. Date sig		
	10		30. Name and address of person	who completed caus	se of death (Iter	n 23a) (Type,	Print)	v Au	€NU!	= BA	LTIM	nore.	mb 21224
	Sta	ite	31. Date filed (Month, Day, Year)		Registrar's Signa	ature							

State Registrar

DHMH 17 Rev 1/2001

DEC 0 5 2006

06-09183 Elizabeth Burke

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Elizabeth bulke		State of Maryland / Department of Health and Mental Hy 1- For State Certificate of Death Registrar		g. No. 200	C 001.71
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle,Last)	2. Date of Deat Month December	200	2030 hrs
wiedicai Examin	EI.	ELIZABETH VIRGINIA HINDLE BURKE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		2, 2006 4c. County of Deat	
		Good Samaritan Hospital Baltimore		N/A	
Funeral Director		$\begin{array}{cccccccccccccccccccccccccccccccccccc$	7	h(MM/DD/YYYY) 9 Bi Forei 5, 1931 Ma	thplace (State or gn gn lftyland
any	ŀ	Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location			10d Inside City Limits
ž .	5	Maryland N/A Baltimore City			1 X Yes 2 No
or iffe	I Director	10e Street and Number 10f. Zip Code 1008 Woodson Road 21212		g. Citizen of What Cou USA	·
ath wit items 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 11. Was Decedent of Hispanic Origin? (Sp. 1f Yes, specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	rican Indian, Black,
ofter de	by Fu	3 Widowed 4 X Divorced If Yes, Give Year or Dates:		Specify: W	hite
hours a	ed b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of vide most of working life. DO NOT use retired.)		16b. Kind of Business	Recreation
336 thin 72 te than "	Completed	Elementary/Secondary (0-12) 12 College (1-4 or 5+) Maintenance Clerk		for Balto	1
21215-0036 Juld be filed within 7 Mental Hygiene marked other than	ဦ	17. Father's Name (First, Middle, Last) 18. Mother's Name		laiden Surname)	
2121 Id be fi Mental narked event,	To Be	Elmer Hindle Elizab 19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or F		ginia Dade	
Baltimore, MD 21215-005 pennit Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Med		Brenda M. Miller (Daughter) 6010 Henderson Avenu		•	
re, re, re, re, re, re, re, re, re, re,		20a Method of Disposition 20b, Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	
Baltimore, permit Pages La Department of He Important: If ite	1	4 Donation 5 Other Specify: Green Mount Crematory 12/			
Ball permit Depart Impor	-4	21 Signature of Funeral Service Ligensee 22. Name and Address of Eacility WIEDEFE	LD FUNE	RAL HOME, 1	INC.
Physician		23a. Part I. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardinc of failure. List only one cause in each line.	r respiratory arre	re <u>Marv</u> Lar st, stock, or heart	Approximate Interval Between Onset and
/Medical Examiner	-	Immediate Cause (Final disease a Hypertensive atheroscelrotic cardiovascular	disease		Death
		or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):			
	je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
T is	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
760, icate be executed physician and the burial - transit	핗	MUNPENDED AMENDED HOOF OF THE ACCOUNTY OF THE			
60, ate be e ohysicia	Medical	#23a,27,PII,28a-f, peME, g863, 1/11/07	7 TT	23d. Date of deliver	
687 certifica ding p	= (23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregna	incy		Day Year
Division of Vital Records, P.O. Box 687 for the Hospital or Attending Physician: The law requires that the death certificate he hours after death or Attending Physician: The law requires that the death certificate has been signed by the attending to the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Physician/	1 Yes 2 ✓ No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
, P.O. B res that the d signed by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		bacco use contribute to	
ls, P quires ti	Completed by	Hip fracture	1 Yes		utopsy findings available
Sord law rec has bee	lbe(autop:	sy prior to	completion of cause of
of Vital Records, F ling Physician: The law requires After this certificate has been sign funeral director, page 2 should be		25 Was case referred to medical 26 Place of Death (Check of De	1 Yes 2	2 No 1 Y	es 2 No
Vita ysiciar this cer	To Be	examiner? 1 Ves 2 No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin		Residence 6 Othe	r:
n of ling Ph After 1 funeral		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	
ivisior or Attend after death Director:	Satic	Natural 5 Pending Investigation 11/21/2006 unknown 1 Yes 2 X No 28e. Place of Injury - At home, farm, street, factory, office building, etc.	subject f		ural Route Number, City
Divi	erti.	3 Suicide 6 Could not be determined (Specify) residence	or Town, St Baltimore	ate) 1008 Woods	on Rd. Apt D
Division To the Hospital or Attent within 24 hours after death To the Fineral Director:	S S	29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the cause	e(s) and manner as star	
To the comple	Medical Certification:	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	t the time, date a		
	≥	29b Signature and title of certifier 29c License number O.C.M.E.		29d. Date signed (Mo	
	}	30. Name and address of person who completed cause of death (Item 23a)			
		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
	ate	31. Date filed (March Day Year) 2006 32 registrar's Signature			
Regist	Сľ	January Na January			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🧘 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** MARGARET F. CLOUD 2:35P M DEC 02 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST CENTER FOR HOSPICE TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex . Age (In yrs, last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 🛛 F 212-32-7701 76 S. CAROLINA Director 01/02/1930 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Exaπlner must be notified at BALTIMORE CITY XXYes 2□No Director N/AMD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4113 BOARMAN 21215 AVENUE USA Pages 1 and 2 should be filed within 72 hours after death vnent of Health and Mental Hygiene. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK þ 3X Widowed 4 ☐ Divorced Completed er than "natur the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry SOCIAL SECURITY Elementary/Secondary (0-12) College (1-4or 5+) CLAIMS ADJUSTER ADMN./ US GOVERMENT 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked or traumatic even LEE HOLSEY EVANGLEE ALLEN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CONSTANCE THOMAS/DAUGHTER 708 S. SHARP STREET, BALTIMORE, MD 21230 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 12/11/06 OWINGS MILLS, D VÉTERANS CEM ARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Experal Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, or the disease, or complications that caused the death. heart failure. List only one cause on each line. Dg ot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** lancrean mortas /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): burial physician at the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 12 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Wester Hospital: 2[**Y**No 1 Tes 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Inpatient မ 28b. Time of 27. Manner of Death 1 Natural 28a, Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C completely filled i 📇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

nontite 7 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

46 N. Charles CHANNEL W) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Posis on ountil

2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 6:41 AM 3, 2006 December James Edward Conner /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Baltimore Washington Medical Center Anne Arundel 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**≧**M 2□F Months 24 79 Director <u>219-22-9770</u> 1927 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. And the them 27 is marked other than "natural", or items 23a or 28a-f show ant; If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo MD Anne Arundel 0denton 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 8608 Wandering Fox Trail #204 21113 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □X/es 2 □ No 1942 If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2★ No Specify. ò 3 Widowed 4 Divorced white 1945 white Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) V.P. Sales Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Malcolm Conner ပ Laura Lehnert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8608 Wandering Fox Trail Odenton, MD 21113

e of Disposition (Name of Date 20c. Location - City or Town, State Lucille T. Conner - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If its any Injury or of once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Dec. 5, 06 Baltimore, MD 21. Signature of Funeral Service Lig 22 Name and Address of Facility 299 Frederick Road Baltimore, MD 21228 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Cremation Society of Maryland, 23a. Part Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hours /Medical Due to (or as a consequence of): Examiner hour mall bowel obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes 1 Inpatient 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu and title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lutharville 1205 York Road #38 21093 I. Leavey. 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

		Otate of Ivia	•	Certificate of		weman ny	Reg. No.	16 :	38463
	1. Decedent's Name (First, Middle, L.	ast)				2. Dete of De Month	eth Day	Y	3. Time of Deeth
Physician	John E. C.	ochrane				Dec	2 200	Yeer	10:01 PM
/Medical Examiner	4e Fecility Neme (If not institution, gi				4b. City, Town, or	10 0.1			
LXammer	Mercy Medica	. 0			Baltim	DIT.		NIA	
Formula	THE COUNT CON		e (In yrs. lest birti	hdev) If Under 1 Yea			th	9. Birthok	ace (State or Foreign
Funeral Director				rs. Months Day	s Hours Min.	8. Date of Bir (Month, Da 7-03-19	918	Mary	ace (Stete or Foreign ry) land
and Mand	10a. State 10b. County		10c. City, Town	or Location				10	d. Inside City Limits
Aarylan f ehow ed at	Maryland n/a		Balt	imore					1 X Yes 2 □ No
uth with the Maryle 23e or 28a-1 show wat be notified at ral Director	10e. Street end Number			10f. Zip Code			10g. Citizen of V	What Count	n/2
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eral			i- 11 0		Historia Ostaio 2 /	>		e - America	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: if Item 27 is marked other than "naturel", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at ance. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Tyes 2 N If Yes, Give Year or Detes:		13. Wes Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ No		opecity Yes or No to Rican, etc.)	Specify	ck, White, e	
2 ho	15. Decedent's E	ducation	16e. l	Decedent's Usual Occi	upetion		16b. Kind of B	usiness/Indi	ustry
pier pier	(Specify only highest gr Elementery/Secondary (0-12)			Decedent's Usual Occi (Give kind of work don life. DO NOT use retir	e during most of wo red)	rking			
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d be santal red c	Thomas Cochran				Margare	t Tiern	ev		
should and Man marke marke	19a. Informant's Name/Relationship	(Type Print)	106	Meiling Address (Stree			, ,	State 7in /	Codel
Ore, Maryland 212 es 1 and 2 should be filed with of Health and Mantal Hygiene filem 27 is marked other tha r other traumatic event, the To Be Com	James Norton	(nephew)		1 S. Charl					,
Hand Health		(HepHew)				Date			- Ctata
Ord First	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [Removal from State		Disposition (Name of r, crematory or other pi			20c. Location -		
Page Page ury	4 Donation 5 Other (Special		Glen Ha	ven Mem. P			5 Glen B		,MD
Baltimopermit. Pag Department Important: If eny injury o once.	21. Signature of Furnital Service Lice		. 1.	22. Name and Add McCully-P	olyniak F	uneral l	Home, P.	A.	
	23s. Pert1. Enter the disease, or con	. Wayne Os	terling	130 E. Fo					Annsavimata
_	23a. Pert1. Enter the disease, or conshock, or heart failure. List only	one cause on each lin	e.	ot enter the mode or dy	ring, such as certia	on respiretory e	11051,	Í	Approximete Intervel Between Onset end Death
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/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Myoc	ardial	infarction	1			Lu	ntnew
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68760, C	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events	0							
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daa daa daa daa daa daa daa da fo eed fo eed fo sici	Part II. Other significant conditions	contributing to death bu	t not resulting in	the underlying cause g	iven in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
P.O. nat the da d by the a setached betached Physic						1 🗆	Yes 2 No	3 Probe	ably 4 Unknow
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cord						24a. Was	en autopsy	24b. Wer	re autopsy findings lable prior to
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of Vital Rec Physician: Tha law this cartificate has braid inector, page 2 strain director, page 2 strain To Be Compi	25. Was cese referred to medical examiner?	Hospitel: 🎉			thor:	eth (Check only o			
of \ Physic this ca al dire	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 🔁 Inpetier		petient 3L DOA	4 LI Nursing F		dence 6 □Oth		
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Vision Attending or death. ector: After by the fune	2 Accident investigetion 3 Suicide 6 Could not to				Yes 2 No				
Division of Vital Records, or attending Physician: The law requires that detector: After this cartificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed by	4 Homicide determined	28e. Plece of Inju building, etc	ry - At home, fari . <i>(Specify)</i>	m, street, factory, office	•	28f. Location (City or To	Street and Numb wn, Stete)	er or Rural	Route Number,
C e a c c c c c c c c c c c c c c c c c c									
Division C To the Hospital or Attending PI within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		nyeician: To the best of niner: On the besis of end manner stel	examinetion end						
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State Registrar	31. Date filed (Month, Dey, Year)	F	r's Signeture	Consider					

DHMH 16 Rev 6/95

ORIGINAL

			1- For State Registrar	tate of Maryl		artment of H	ealth and Men	tal Hygie		38464
	Physic /Medi		1. Decedent's Name (First, Middle, Last)	IKLIN	Colli	NS	1	Date of Death	Day Year	3. Time of Death
	Exami Funeral Director	ner	4a. Facility Name (If not institution, give street HARBUR HUS) 5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	P.2 T.A L.	rs. last birthday)		Hours Min. (Date of Birth Month, Day, Ye	N/A N/A 9. Bin	
	D	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Aruno		City, Town or Lo	cation Glen Bu		ug 10,	1920 Wes	10d. Inside City Limits
	3a or 28a-f	Funeral Director	10e. Street and Number 1669 Marley			10f. Zip Code	21060	10g.	Citizen of What C	1 □Yes 2 ♣No ountry?
980	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural", or iteme 23e or 28e-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married	Vas Decedent Ever in the comment of		Vas Decedent of His f Yes, specify Cubar □ Yes 2 1 No	spanic Origin? (Specify n, Mexican, Puerto Rical Specify:	Yes or No- n, etc.)	14. Race - Ame Black, Whi	
Maryland 21215-0036	id within 72 ho giene. er than "natur i the Medical	Completed	15. Decedent's Educatio (Specify only highest grade core Elementary/Secondary (0·12)	n	16a. Deced (Give life. L	lent's Usual Occupa kind of work done d DO NOT use retired) Ceam Engin	uring most of working		. Kind of Business	
yland	should be file and Mental Hy marked oth umatic event	To Be		Collins			18. Mother's Name (Fire Sara	ah Lle	oyd	
	1 and 2 s Health ar am 27 ls ther trau		19a. Informant's Name/Relationship (Type, Mary L. Collins 20a. Method of Disposition	(Wife)	1669	Marley A	Ave., Glen l	Burnie,		50
Baltimore,	permit. Pages Depertment of it Important: If Its any Injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funer Service Licensee	val from State C Kevin E E	01	natory or other place I Cemeter Name and Address	of Cooling	6 Bal	ltimore,	Maryland
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ns that caused the duse on each line. WASSLV Due to (or as a cons Due to (or as a cons	eath. Do not enter the sequence of):	er the mode of dying	Solyniak Fune Capsco Ave., such as cardiac or resp V2AL Hrs	piratory arrest,		21225–1856 Approximate Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be execu- ate has been signed by the attending physicien and page 2 should be detached for use as the burial-tra	Physician/Medical	in the past 12 mentits? 1 ☐ Yes 2 ☐ No 4 9 ☐ Unknown 9	yes, outcome of preç □Live birth 2 □ Fr □ Pregnant at time o □ Unknown	etal death 3 f death 5	Ectopic pregnancy Other (specify)			23d. Date of deli	ivery Day Year
Vital Records, F	ie law requires tha has been signed ge 2 should be de	Completed by P	Part II. Other significant conditions contribut	ing to death but not r		derlying cause giver		1 Yes	2 No 3 □ Pro	the cause of death? bably 4 Unknown topsy findings available
Vita	Physician: The lab. this certificete har director, page	To Be Con	25. Was case referred to medical examiner? 1 Yes 2 No Hospit	1 Impatient 2	☐ ER/Outpatient	1 04	26. Place of Death Che		death?	20140 cause of
Division of	or Attending I	Certification;	1 Matural 5 Pending 2 Accident investigation	a. Date of Injury (Month, Day Year) e. Place of Injury - At building, etc. (Spe	home, farm, stre		es 2 □ No 28f. Lo	Describe how injude the control of t	and Number or Ru	ral Route Number,
	To the Hospital or within 24 hours after To the Funaral Direction or mpletely filled in the function of the following the follow	edicai		To the best of my k In the basis of examind and manner stated.	nowledge, death nation and/or inve	estigation, in my opir	nion, death occurred at t	he time, date ar	nd place, and due	to the cause(s)
	~ {\\		29b. Signature and title of certifier July Hur 30. Name and address of person who complete		em 23a) (Type, P	29c. License r		29d. D.	ate signed (Month	, 3 , 2006
	Sta Registra	e	OHT K T . Z . 31. Date filed (Month, Day, Year) DEC 0 5 2006	- HAR	nature	5178 TAL	, 300 t So	oth the	never Si	, 3, 2006 but, but he 10 21225

		1	For Stete Registrer	State of Ma	ryland / Depa <i>Cei</i>	artment of H rtificate of L		lental Hygie Reg.	/ 11115	38465
H	Physicia		1. Decedent's Name (First, Middle, Last) Mary Elizabeth (Crusan				2. Date of Death Month 11-30-2	Day Year	3. Time of Death 7:00am
	/Medic Examin		ta. Facility Name (If not institution, give st 9310 Hines Estat			4b. City, Town, or Parkvi	Location of Death		4c. County of Dea Baltimo	th
I	Funeral Director		5. Social Security Number 6. Sex 10	7. Age	(In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 1 - 30 - 19	23 Geo	thplace (State or Foreign ountry) orgia
	show		Usual Residence of Decedent 10a. State 10b. County MD Baltimon		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🕍 No
	with the M a or 28a-f Le notifie	Director	10e. Street and Number 9126 Orbitan Rd.		LUIXVIII	10f. Zip Code 21234			Citizen of What Co	ountry?
0	ufter death rritema 23 ofter man	Funeral	11. Marital Status 1:	2. Was Decedent E Armed Forces? 1 Yes 2 No	,	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Spin, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	te, etc.
Maryland 21215-0036	d within 72 hours after death with the Maryland jiene. Than "natural", or itema 23a or 28a-f show The Medical Examinant must be notified at	eted by	3 X Widowed 4 □ Divorced 15. Decedent's Educ (Specify only highest grade	If Yes, Give Year or Dates: ation completed)	16a. Dece	dent's Usual Occupa	ation during most of work	ing 16t	Specify: Wh	
1212	filed within Hygiene. other then '	Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5-	-)	de Sale	s Rep.	I e (First, Middle, Mail	nsuranc	е
ıryıanı	and Mental and Mental in marked o	To Be	Amos Milhouse El		19b. Maili	ng Address (Street a		Maude Be		Zip Code)
	1 and 2 Health a am 27 is than tra		Shirley Traub-Da			HInes I		-	kville,	MD 21234 Town, State
Baltimore,	permit. Pages Depertment of Important: If it any injury or o once.		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Periods	111	Evans Fu	neral H	ome 5, a	2006 FO	rest Hi	ll,MD n Servic e S
n E	88 E 8 8		23a. Party. Enter the disease, or complic shock, or heart failure. List only on	ations that caused a cause on each line	the death. Do not en	ter the mode of dyin	ford Rd.	Parkvil or respiratory arrest	le,MD21	2 3 4 Approximate Interval Between Onset and Death
E	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as	consequence of):	hishoc	ytoma			11 yrs
1	4	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
8760,	death certificate be executed e attending physician end of for use as the burial-transit	dicai Exar	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):					
Box 68	eath certificate attending phy for use as the	n/Medic	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of		□Ectopic pregnancy		* * * * * * * * * * * * * * * * * * * *	23d. Date of de	
P.O. B	that the death led by the atte detached for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 Œ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	time of death 5	Other (specify)			Month	Day Year
	The law requires that the ste hes been signed by th page 2 should be detache	۵	Part II. Other significent conditions con	tributing to death bu	t not resulting in the t	underlying cause giv	en in Part I.			to the cause of death? Probably 4 (Honknown
l Reco	The law re ete hes be page 2 sh	Completed						24a. Was an autopsy performer	prior to death?	utopsy findings available completion of cause of
Vita	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No H	ospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatie	ont 3□ DOA Oth	00	h (Check only one)	a s Thether (So	daughters
on of	Attending Physician: or death. ector: After this certification is the funeral director.	ion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	y 28b. Time (of 28c. Injur Wor	y at	28d. Describe how		ocity) have
Division of Vital Records,	for Attendi after death. Director: A I in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Inju- building, etc	iry - At home, farm, s :. (Specify)			28f. Location (Stree City or Town, S	et and Number or F State)	Rural Route Number,
7	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Exeminates							
	To th To th	Me	29b. Signature and title of certified	12		29c. Licens	06244	£5 29d	Date signed (Mor	oth, Day, Year)
	6			nov MD	eath (Item 23a) (Type	ampbell	Blud B	ts 290	e MD	21236
	St Regist		31. Date filed (Morth, Day, Year) DEC 0 5 20	32. App istra	ar's Signature	Carles				

			1 - For Amend #3Pe	State of M r Phy &	aryland 18 Per	/ Depa FH G Cer	urtment of I 862 JH <i>tificate of</i>	lealth <i>Death</i>	and M	lental Hyç	giene Reg. No 2 1	06	391.66
	Dhyoic	on.	1. Decedent's Name (First, Middle,							2. Date of Dea	ath	<u> </u>	3 Time of Death
I E	Physic /Medi		SHARON ANNE DANNENF	ELSER						Month NOVEMBER	28, 2006	Year	6:15-P
	Exami	ier	4a. Facility Name (If not institution, g	give street and number)			4b. City, Town, o	or Location	of Death		4c. County	of Death	
			517 PATUXENT AVE. 5. Social Security Number 6	6	- 11-	1154 4 1	BALT I MOR		0411		BALTIM		
ш	Funeral Director			. Sex 7. Ag	je (In yrs. las	Yrs.	Months Days	If Under Hours	Min.	8. Date of Birtl (Month, Day		Count	
			216.52.2218 Usual Residence of Decedent	XX	57					July 2	9, 1914 9		MD
	rylan how		10a. State 10b. County		10c. City, T	Town or Loc	cation					10	Od. Inside City Limits
	e Ma Ba-f s	Director	MD BALTIMO)RE	BALTI	MORE							1 ☐ Yes 2 ☐ No XX
	or 28	Dire	10e. Street and Number				10f. Zip Code				10g. Citizen of V	Vhat Count	
	ath w	ra	517 PATUXENT AVE.				21237				US		
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. No	"	Vas Decedent of H Yes, specify Cub ☐ Yes (XX) No	lispanic Or an, Mexica Specify.	n, Puerto i	cify Yes or No- Rican, etc.)		e - America k, White, e	
5-0036	2 hours atural", cal Exa	ed	15. Decedent's	Education	1 1	l 16a. Deced	ent's Usual Occup	oation		-	16b. Kind of Bu	ITIKW siness/Indi	
215		Completed	(Specify only highest (Elementary/Secondary (0-12)	grade completed) College (1-4or 5		(Give I life. E	kind of work done O NOT use retired	during mos d)	st of workir	ng			ustry
2121	filed within Hygiene. Ither than ' nt, the Me	8	12			BUS A	TTENDANT				TRANSPO		DN
Maryland	be fill tal H doth even	Be	17. Father's Name (First, Middle, La	st)							Maiden Surnam	-/	_
<u> </u>	ould d Mer narke	은	JOSEPH WHEELER										sa Loucks
Ma	alth and 2 shalth and 27 is n		19a. Informant's Name/Relationship	(Type. Print)			g Address (Street					State, Zip (Code)
á,	Heal Heal tem 2		JOSEPH DANNENFELSER 20a. Method of Disposition		20b. Place		ATUXENT AVE	E. BALT			7 20c. Location -	City or Tou	un Ctata
Baltimore,	e = 5		1 ☐ Burial 2 XX remation 3 4 XX onation 5 ☐ Other (Spe		cem	etery, crem	atory or other plac	í.					vii, State
äĦ			21. Signature of Funeral Service L		PURTI	22.	REMATORY Name and Addre	ss of Facili		2006	PORTLAND), OR	
ä	Depa Impo any ii		CRECORY FINK	1 the	M01148		NK FUNERAL 5 CRAIN HWY			BNIE MD	21061		
	(26 W)		23a. Part Enter the risea e, r co	u plications that caused									Approximate
	Physician		Immediate Vuse (Final disease or condition	y one cause on each in	VA	2:41	()	on el	71				Interval Between Onset and Death
7	/Medical		resulting in death)	a. Due to (or as	a consequen	ce of):		11 4	4				15 years
	Examiner		Sequentially list conditions	b									-
	D # 1	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequen	ce of):							
	icate be executed physician and the burial-transit	am	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c									
60,	be ex ician burial	四日		Due to (or as	a consequen	ce or):							
68760,	ficate be execut physician and s the burial-trar	dical		d									
	certi ding se a	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy	,							
Box	death e atten	by Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal de	ath 3□I	Ectopic pregnancy Other (specify)	1			23d. Date Mor	of deliver	y Day Year
P.O.	the cay the	Jysi	1 □ Yes 2 □ No 9 □ Unknown	9□Unknown			- mar (apacity)						
	The law requires that the do ate has been signed by the a page 2 should be detached	Y	Part il. Other significant conditions	contributing to death bu	ut not resulting	g in the und	derlying cause give	en in Part I.		23e. Did tob	acco use contri	bute to the	cause of death?
Records,	quire en sig uld b									1 □ Ye	s 2 No	3 Probal	bly 4 ∐Unknown
ည္က	aw re ts bee	Completed								24a. Was ai		/ere autops	sy findings available
Ä	The ate has	E O								autops perforn 1 Yes 2	y pa nyed?_ da	rior to com _l eath?	pletion of cause of !□ No
Vital	stan: ertifica ctor, I	Be	25. Was case referred to medical examiner?					26. Place	of Death	(Check only on	7	□Yes 2	: 🔲 140
or V	Physician: r this certific ral director,	2	1 Yes 20 No	Hospital: 1 ☐ Inpatie	nt 2 ER/	Outpatient	3□ DOA Othe	er: 4□Nu	rsing Hom	e 5 Reside	nce 6 □Othe	r (Specify)	
טע	ing P		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day		b. Time of Injury	28c. Injury Work				w injury occurre		
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not	ho -				Yes 2 □ I	No				
Division	I or Attend after death. Director: /	Certification:	4 ☐ Homicide determine		ry - At home, :. <i>(Specify)</i>	, farm, stree	et, factory, office		28	3f. Location (Sti City or Town	reet and Numbe , State)	r or Rural I	Route Number,
	putal ours a eral filled		29a. Certifier Certifying F	Physician: To the best of	of my knowled	dae death	occurred at the time	no deto en	1 -1				
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check only one)	aminer: On the basis of and manner sta	examination	and/or inve	estigation, in my o	pinion, dea	th occurre	nd due to the ca d at the time, da	ause(s) and mar ate and place, a	ner as stat nd due to t	ted. he cause(s)
	ro th ro th compl	≧	29b. Signature and title of certifier) 1	1		29c. License	number		29	d. Date signed	(Month, Da	av, Year)
	2		+ Parl (llon	, VW	D	D	309	129		11/291	/200	06
	J		30. Name and address of person who	completed cause of de	lotte 23a	(Type, P	Ohin I	(on (7	RAIT	Trumo	100	212011
	Sta	e	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	/ /	-	<i>5/3</i>	1	DING	11104	11V)	21207
	Registr	ar	DEC 0 5 200	6 Bearing	S. A.	POBAGE	3						
DIII	411.47 Day 4/00	01		69	6								

Registrar DHMH 17 Rev 1/2001 Shane Adam Dressel

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Of Maryland / Department of Fleath and Memar Registrar	_	eg No.	
Physic	an/	Decedent's Name (First, Middle, Last)	2. Date of Dea	th /	3. Time of Death 1
Medical Exam	iner	Shane Adam Dressel	Novembe	r 30, 2006	1612 hrs
		4a Facility Name (if not institution, give street and number) 4b City, Town, or Location of De	eath	4c. County of Dea	
		213 Ridgley Road Glen Burnie		Anne Arunde	el
Funeral		5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	N.G.	rth(MM/DD/YYYY) 9. E Fore	irthplace (State or
Director		215-13-6473 1X M 2 F 23 Yrs. Months Days Hours	Min. 12 – 06-	-1982	ountry) MD
		Usual Residence of Decedent			_
v an		10a. State 10b County 10c. City, Town or Location			10d Inside City Limits
and F showner.	5	MD Anne Arundel Glen Burnie			1 Yes 2 X No
Maryland 28a-f show any d at once.	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	untry?
th the Maryland 23a or 28a-f sho notified at once.	اقا	213 Ridgely Road 21061		U.S.A.	
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. ifem 27 is marked other than "matural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? 1 Yi Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Put		14 Race - Ame White, etc.	erican Indian, Black,
deat or ite	틧	1 Yes 2 X No	orto Mcari, etc.)	vviiite, etc.	
after	þ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify or Dates:			rican Indian
hours natui		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		16b. Kind of Business	/Industry
36 n 72 nan "	plet	Elementary/Secondary (0-12) College (1-4 or 5+)			
with with	Completed	12 Sheet Metal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	ame (First, Middle, I		uction
1215-0036 It be filed within 73 dental Hygiene. narked other than event, the Medical				,	
2121 uld be fi Mental marked c event,	To Be	19a Informant's Name/Relationship (Type, Print) father / 19b. Mailing Address (Street and Number	ce Marcia	Locklear	a Zin Cada)
MD 21215-0036 Id 2 should be filed within 7 lith and Mental Hygiene. n 27 is marked other than aumatic event, the Medica	1	Mr. Daniel Conrad Dressel 213 Ridgely Road; G			
e, MC l and 2 sl Health ar item 27		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date Date	20c Location - City of	
nore tages nt of F other		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	05 0006		
Baltimore, permit Pages I an Department of Hee Important: If ite				Glen Burn	
Baltimorr permit Pages I Department of I Important: If injury or other			Singletor	Funeral H	ome, PA
		23a Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia			061 Approximate Interval
Physician /Medical		failure List only one cause on each line.	ac of respiratory and	est, snock, or near	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot Wound of Head Due to (or as a consequence of):			Death
		h h			
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of).	· ·	-	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):			
ted 1	EX	events resulting in death) Last Due to (or as a consequence of): d.			
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED			
760, icate be physiciate buriate the buria	led	IF FEMALE. 23c. If yes, outcome of pregnancy		22d Date of deliver	
876 tifica ng ph as the		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant	gnancy	23d. Date of delive Month	Day Year
Box 68: death certiff the attending of for use as:	sician	4 Pregnant at time of death 5 Other (Specify)			
Bo e dea the a ted fo	Phys	1 Yes 2 No 9 Unknown 9 Unknown			
P.O. E es that the cigned by the be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	
S, P irrest sign d be o	pe t		1Yes	2 V No 3 Pro	bably 4 Unknown
ords, w requir s been s	Completed		24a Was autop		utopsy findings available completion of cause of
Reco The law cate has	E	-	perfor	med? death?	es 2 No
tal Recirian: The certificate		25. Was case referred to medical 26.Place of Death (Che			55 2 115
Vita ysicia his ce direc	To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nu	rsing Home 5	Residence 6 🗸 Othe	er Scene
n of Vital Records, ding Physician: The law requir After this certificate has been si funeral director, page 2 should b		27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work?		now injury occurred	
Division tal or Attendiars after death all Director: A led in by the fu	tio	1 Natural 5 Pending FOUND: Day, Year) 2 Accident Investigation Nov 30, 2006 FOUND: 1 Yes 2 No	Subject sho	t seit	
ivision or Atten after deatt Director:	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office building, etc.			ural Route Number, City
Divis pital or At ours after d eral Direct filled in by	Certification:	4 Homicide determined (Specify) Single Family	or Town, S 213 Ridgley R	^{tate)} oad, Glen Burnie, M	D
Hos 24 b Fun		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a			
To the Howithin 24 E	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated	ed at the time, date	and place, and due to t	ne cause(s)
_ » _ 3	M	29b. Signature and title of certifier 29c. License number		29d Date signed (Mo	onth, Day, Year)
		Can to Souther W. O.C.M.E.		December 1, 20	06
10		30. Name and address of person who completed cause of death (Item 23a)			
10		Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore	, MD 21201		
	tate	31. Date filed (Month, Day, Year) OFC 0.5. 2006 32/Registrar's Signature			
Regis	trar	DEC 0 5 2006 All 10 10 10 10 10 10 10 10 10 10 10 10 10			

Certificate of Death

20c. Location - City or Town, State Bel Air, MD Name and Address of Facility
Vans Funeral Chapel 8800 Harford Rd.
Id Cremation Services Parkville, MD, 21234 Approximate Interval Between Onset and Death 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 7 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INDEN

38468

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

Maryland

white

2006

USA

Specify:

14. Race - American Indian.

Anne Arundel

4c. County of Death

31. Date filed (Month, Day, Year) State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

1 - For State Registra

82 DAVE DEC 0 5

2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mary Eilnor Douty 2006 Dec 5:30 a.™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3925 Beech Ave. Apt. 424 Baltimore n/a If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 15,1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 217-12-0744 87 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 yes 2 No Directo Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3925 Beech Ave. Apt. 424 21211 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes ŽXNo If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes XX No Specify: \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Microbiologist Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth Knell Moore Mary King Nelson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Marshall Asher (POA <u> 2 Hamill Road Baltimore, Maryland 21210</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 12/5/06 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld F.H. 6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or complication and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Physician eta STA Weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conse wence of Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending properties of IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has l irector, page 2 s autopsy performed2 2 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury n 24 hours after death. le Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 4, 2006 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Charles St. Baltinore, Md 2120 x

Registrar

State

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

6701

32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death - 27, **Physician** GERTRUDE BREHM GOLDBACH DREW 2006 5:25 P M November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Tovison | Year | If Under 24 Hrs. Baltimore County

9. Birthplace (State or Foreign Country) HOSPICE OF BALTO AT GILCHRIST CENTER If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours 1 □ M 2 👿 F Director 90 216-44-4689 Feb 11, 1916 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🎇 No Director Baltimore County Pikesville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21208 920 Adana Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: White 9 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Residence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Goldbach Leo J. Gertrude Brehm ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Emmans Road, Flanders, New Jersey 07836 (Son) William H. Drew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Mount Crematory 11/29/2006 Baltimore, Maryland 21. Signature of Funeral Sauce Consee Martin D. Lawson 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximated in the control of the control o Approximate Interval Between Onset and Death eust Ancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-transi and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1- Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Name and address of person who completed cause of leath (Item 23a) (Type, Print)

Year)

32. Registrar's Signature

November 27, 2006

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			riease	Type or Print in t				•	•	
			1 _ State	State of Marylan	-			Mental Hy	3000	381.71
			Registrar 1. Decedent's Name (First, Middle, La	out .	Ce	rtificate of	Death		Reg. No. UUD	
	Physici /Medio		JOHN EN	HLES				2. Date of De Month	Day Year	3. Time of Death CSSOGAM
	Examir	ner	4a. Fecility Name (If not institution, give		od an	4b. City, Town,	or Locelion of Dea	12.	4c. County of Dea	
			5. Social Security Number 6.5	ASHATO NO.	last highday	If Under 1 Year	If Under 24 Hr	8. Date of Bir	*******	
	Funeral Director			20 W 20 W	7 Yrs.	Months Days			19, Year) 9. Bi	rthplace (State or Foreign ountry)
	and *		Usuat Residence of Decedent 10a. State 10b. County	10c. Gif	y, Town or Lo	ocation			7	10d. Inside City Limits
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	r 28a	Director	10e. Street and Number	under F	asaue	10f. Zip Code			10g. Citizen of What C	ountry?
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	eep	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent of I	Hispanic Origin? (pan, Mexican, Pue	Specify Yes or No	14. Race - Am Black, Wh	
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	To the Hospitel or Attending Physicien: within 24 hours aftar death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	(Check only 2 Medical Exar	nysician: To the best of my kno niner: On the basis of examina	wledge, death	occurred at the til	me, date and place	e, and due to the ourred at the time,	cause(s) and manner a	s stated.
	thin 2 thin 2 the implet	Med	29b. Signature and little of certifier	and manner stated.		29c. Licens			29d. Date signed (Mon	
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	Sta Registr		31. Date filed (Month, Pay, Year)	32. Refistrar's Signa	ture	Last 2				/ -

			1 - For State Registrar	State of Maryla	ind / Depa <i>Cei</i>	artment of H <i>rtificate of</i>	leaith and <i>Death</i>	d Mental Hy	/giene2	006	38472
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	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23e or 28e-f ehow or other traumatic event, I'm Medical Examinar must be notilized at	rai Director	Usual Residence of Decedent 10a. State 10b. County MD 10e. Street and Number 2102 Poplar Gro		City, Town or Lo	nore	1216		10g. Citizen	of What Coun	Od. Inside City Limits 1 Yes 2 □ No try?
900	ours after de rei', or items Exeminar o	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 217 No If Yes, Give X Year or Dates:		Was Decedent of H If Yes, specify Cubi 1 ☐ Yes 2100 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		Race - America Black, White, e cify: b1	
Maryland 21215-0036	ed within 72 h giene. er then "natu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation o completed) College (1-4or 5+)	(Give life. I	dent's Usual Occup kind of work done DO NOT use retired disabled	during most of w	vorking		Business/Inc	dustry
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DIVISION OF VITAI	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 A Inpatient 2[28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injun Work	or: 4 🗆 Nursing	eath Check only o Home 5 Resid	dence 6 □C		
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			1 - For State Registrar	tate of Maryland / [Department of H Certificate of L			ene 006	38473
	Physici	20	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		JOSEPH FR		RRELL		11 1	Pay 2006	23444
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			5. Social Security Number 6. Sex	7. Age (In yrs. last birt		R SPR	N Date of Birth	MONTGO	
ŀ	Funeral Director			200	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Y May 19,	9. Bin 1918 1 N	hplace (State or Foreign buntry)
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036	72 hours after death with the Maryland natural', or iteme 23a or 28a-f ehow disal Examinar must be notified at	þ	¥	If Yes, Give Year or Dates:	1 ☐ Yes 2 No	Specify:		Specify: W	HITE
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or iteme 23a or 28a-f show eny foliuty or other treumatic event, the Mardical Examiner must be notified at once.		21. Signa ure Funer Service Licensee Rouald S. Wad	le. Nirector	State Anat Baltimore,	s of Facility Comy Board MD 2120	d 655 W.	Baltimore	Street
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8760,	se be	call	d.						
9	ng ph as th	Medi	IS SELVIN S						
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P.O.	The law requires that the death certificate be executed to hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physiclan/Medical Examiner		4□Pregnant at time of death 9□Unknown	5 Other (specify)			Month	Day Year
	that t	y Ph	Part II. Other significant conditions contribu	uting to death but not resulting in	the underlying cause giver	n in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Division of Vital Records,	quires nn sign uld be	ed by					1 ☐ Yes	2 □ No 3 □ Pro	babiy 4 Unknown
ဝ္	awre s bee 2 sho	Completed					24a. Was an	24b. Were aut	opsy findings available
Ä	The lav	E					autopsy performed 1 ☐ Yes 2 🗵	prior to c	ompletion of cause of
<u>i</u>	ilcian: Th	Bec	25. Was case referred to medical examiner?			26. Place of Death		10 103	273110
<u>></u>	Physic this ce al dire	2	1 ☐ Yes 2 No Hosp	1 ☐ Inpatient 2 DER/Out	patient 3 DOA Other	4 Nursing Hon	ne 5 🗆 Residence	e 6 □Other (Spec	ıfy)
Ĕ	Attending Physician: r death. ector: After this certifice by the funeral director.	on:	27. Manner of Death 2. 2 Natural 5 ☐ Pending	Ba. Date of Injury (Month, Day Year) 28b. Ti	jury Work?		8d. Describe how i	njury occurred	
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<u>></u>	l or Attendetter deatt Ofrector: I in by the	Certification;	4 Homicide determined	Be. Place of Injury - At home, fare building, etc. (Specify)	m, street, factory, office	2	City or Town, S	t and Number or Rui tate)	ral Route Number,
	To the Hospital or Attending Physician: The within 24 hours effer death. To the Funeral Director: Affer this certificate h completely filled in by the funeral director. page		29a. Certifier Certifying Physicia	n: To the best of my knowledge,	death occurred at the time	e, date and place, a	nd due to the cause	e(s) and manner as	stated.
	the Ho in 24 the Fu	ledical	one)	On the basis of examination and and manner stated.	/or investigation, in my opi	nion, death occurre	d at the time, date	and place, and due	to the cause(s)
1	To To To	Σ	29b. Signature and title of certifier	2	29c. License	number	b 1 29d.	Date signed (Month	, Day, Year)
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			30. Name and address of person who comple			2 5.5	3 0 000 000	2 222 2	285
	Sta	te	DR TRUONG BAC 31. Date filed (Month, Day, Year)	32 Panistrar's Signature	DICAL CTY	IN THE K	COCKVILL	K 1410 3	0850
	Registra		DEC 0 5 2006	The side of the	E/021431				

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 3:47 PM /Medical November 2006 28 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number If Under 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F Months Hours Yrs. 86 Director 213-03-7222 10,1920 MD Jan. Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be n 8832 Walther Blvd Funeral I 21234 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5 Homemaker Own Home 17, Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be ealth and Mental Lazar Zowadski Ann Zowadski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health ar
Important: If item 27 Is
any injury or other trau Ms. Diana Montgomery / Daughter 1824 Norfolk Road GLen BUrnie MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Park 2006 Glen Burnie, MD 21. Signature Full ry Service License 22. Name and Address of Facility Singleton Funeral Home, P.A. Second Avenue SW Glen Burnie, MD 21061 23a. Part 1 Enter tipe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) heum **Physician** /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed Examin and Due to (or as a consequence of) Box 68760, burialphysician s the burial Physician/Medical certificate as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery that the death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Ö the 9 Unknown signed by t σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ The law requires 1 🗌 Yes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform page certificate 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? After Certification: 28d. Describe how injury occurred or Attending Natural 5 Pending ours after death.

neral Director: A
v filled in by the ft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral Completely filled i To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or ovestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date sjigned (Month, Day, Year) 06 30 Name and address of person who completed cause of death (Item 23a) (Type Summer Total We 800 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

				State of Maryland / Department of Health and N 1- State Registrar Certificate of Death	Mental Hygie	7006	38476
				Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
		Physici /Medio		Kenneth Fields	1 7	Day) Year	10338
	4	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County of Death	
5				Smai Mospital of Bultmore Bultmore C	-47	N	IA
2		Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Cou	place (State or Foreign ntry)
Pelds		Director		Usual Residence of Decedent	Dec 29 1	929	WD
7		yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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X		or 28	Directo	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cou	ntry?
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enne		er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerlo	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
1	36	rs aft	by F	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No Army 1 □ Yes 2 □ No Specify: 3 □ Widowed 4 □ Divorced Year or Dates:		Specify: (3)	
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¥	2	filed wit Hygien ther the	Con	12 NIA Post Master	71	Yost OF	Fice
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OWN	3	ould be d Mental narked c	٩	James Fields Etta	War	<u>e</u>	0-1-1
3	Maryland	12 st h and 7 le n traun		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur	1	ity or Town, State, Zij	
-1		s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 le marked other than other traumatic event. Ite Me		20a Method of Disposition (Name of	Date 200	Location - City or To	3130*7 own, State
T	on I	6 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery, crematory or other place)	2-06	3. Ha. A	ND.
4c	Baltimore	그 된 원 등 .		21. Signature of Facility 22. Name and Address of Facility	2-00	201101	21229
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4	-	Physician		Immediate Cause (Final disease or condition a ischemic Cardiony opath	~/		Onset and Death
		/Medical Examiner		resulting in death) Due to (or as a consequence of):	1		1000
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	0	ulng Phys n. After this funeral di	L:u	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how i		,,
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	Ξ̈́	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	t and Number or Run tate)	al Route Number,
		pitei ours al aral D	Ce	200 Codiffice MC Continues Obversioner To the heat of any least death to death	2010 1010 1010	444 - 475 - 200	
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		To the Hospitel or Attendl within 24 hours after death. To the Funaral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month,	Day, Year)
)			MD BS 931657	27 D	ec 1.	Z006
		H				0 0 1	2006
		\		30. Name and attress of person who completed cause of death (Item 23a) (Type, Print) MUH V2 Suit HDSF 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ital of	isalt	more
		Sta Registi		31. Date filed (Month, Day, Year) DEC 0 5 2006 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, ŽÕØ6 Month Day DECEMBER NANCY ELLEN FORGIONE 04:30AM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Towson Baltimore Saint Joseph Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 3, 1952 9. Birthplace (State or Foreign Months Days Hours Min. Mary Land 54 218-62-1060 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Harvest Road 21210 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) University College (1-4or 5+) 5 + Elementary/Secondary (0-12) Education College Instructor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Forgione Philomena Cedrone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) A. Michael Hill (Husband) 7 Harvest Road, Baltimore, Maryland 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 12/7/2006 Baltimore, Maryland 21. Signatural paper year Lichney Martin D. Lawson 22. Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, proximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 16 HOURS disease or condition resulting in death) SEPTIC SHOCK Due to (or as a consequence of): 16 HOURS DISSEMINATED INTRAVASCULAR COAGULOPATHY Due to (or as a consequence of): 16 HOURS NEISSERIA MENINGITIDIS Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an 1□ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident

Physician /Medical Examiner

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After this certificate

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funeral

Il Director: A

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Box 68760,

P.O.

Division or Vital Records,

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Pages 1 and 2 s nent of Health an ant: If Item 27 Is I ury or other trau

Department of Important: If It any injury or conce.

Maryland 21215-0036

altimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

28a. Date of Injury (Month, Day 5 Pending investigation

28b. Time of

28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier one)

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature a

29c. License number

ER DRIVE

D35453

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Sign

TOWSON MARYLAND 21204

State Registrar

			1 - For State Registrar	State of M	larylan		artmer rtificat			and M	-	giene Reg. No	2001	5	384	78
	Physici		1. Decedent's Name (First, Middle, La	sı) Gerard							2. Date of De	ath Da 2	y za		3. Time of	Death)3 PM
	/Medic Examin	_	4a. Facility Name (If not institution, giv	e street and number)		4b. City,		Location o	of Death			. County of D	4	10	<u>`</u>
			Mercy Medical	Center		In a bint do	BO	1111	10/e	24 Hrs	9 Date of Rie		altimo			. Fa lan
	Funeral Director		5. Social Security Number 6. S 220–11–5851		32	last birthday) Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da Dec.	31,	1973 M	Counti	ice (State or y) Land	r Foreign
	p .		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation								d. Inside Cit	v Limits
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	th the	lrec	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of What	Count	y?	
	ath wi	rai	438 North Carolin	·				1122				7	nited S			
	ter de	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces 1 Yes 2	?	.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Origin, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - A Black, W			
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Maryland	C1 40 = 0		19a. Informant's Name/Relationship (Marion F. Hall /			P.O.	Box	912	438 i Pasad	Vorti	n Carol Maryl	ina and	Aye. 21122	в, <i>zip</i> (2000)	
Baltimore,	es 1 and of Health f item 27 r other tr		20a. Method of Disposition 1 Burial 2 Cremation 3	Damoval from State		Place of Dispo emetery, crer	sition (Na.	me of			nber 4,	20c. L	ocation - City			
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ord	w require been si should t	ted	Slizure disorde	,							1 🗆	Yes 2	! No 3	Proba	bly 4 DU	Inknown
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tal		ပိ	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes	2 0 N			P No	
f Vi	S .S .D	To B	examiner? 1 ☐ Yes 2 🗖 No	Hospital:	ient 2 🗆	ER/Outpatier	nt 3 D	Oa Othe	200		me 5 ☐ Resi		6 ☐Other (S	pecify)		
0 0	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury		28c. Injun World			28d. Describe	how inju	iry occurred			
Division of Vital Records,		Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Ir	njury - At ho	ome, farm, str	M reet, factor		Yes 2 □ I		28f. Location (City or To		nd Number or	Rural	Route Numi	ber,
	Hospital or 44 hours afte Funeral Dis tely filled in						h		- 4	d = 14 = -						
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director:	Medical	29a. Certifier 1 X Certifying PI (Check only 2 Medical Example)	nysician: To the bes miner: On the basis and manner s	of examina	tion and/or in	vestigation	n, in my op	ie, date an pinion, dea	th occurr	ed at the time,	date an	of and manner of place, and o	as sta due to t	ted. the cause(s))
	To the within 2 To the complei	Me	29b. Signature and title of certifier	110	2			c. License					ate signed (Me			
	/		> yutaist	W, M	٠٥.			DO	466	0	/	Nove	mber	14	2004)
	b		111111111111111111111111111111111111111	1 St. Paul	Place	n 23a) (Type,	Print). altim	iore,	Mary	lan	d 213	202				
7	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 5 2	32 Regist	trar's Signa	here Jos	and I									

		Pleas	e Type or Pri							ible.		
		_ For	State of M	aryland	/ Depa	artment of H	lealth and I	Mental Hy	giene			
		1 - State Registrar			Cei	rtificate of	Death		Reg. No. 2 (06	38479	
Physici		1. Decedent's Name (First, Middle,	Last)					2. Date of De	eath	V	3. Time of Death	
/Medic		JOSHUA				GU	TMAN	Decemb	er Day 2	Year 2006	1:59 AM	
Examir	ner	4a. Facility Name (If not institution, g	give street and number)	1		4b. City, Town, o	r Location of Death		4c. Count	y of Death		
		Sina Hospita		move		Baltir					N/A	
Funeral		5. Social Security Number 6 212-40-0264	. Sex 7. Ag	ge (In yrs. las	s <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 06/02/1	th ay, <i>Year)</i>	9. Birth	place (State or Foreign	
Director		Usual Residence of Decedent	^	65				ψ6/02/1	941		<u>MD</u>	
ylanc now at		10a. State 10b. County		10c. City,	Town or Lo	cation				1	10d. Inside City Limits	
a-fsh	ctor	MD N	/ A	BAI	LTIMO	RE					X [□] Yes 2□No	
th the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?	
23a ust b	la	3819 MENLO DR	IVE			21215			U.S.A			
er deg	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	>	13. \	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No Rican, etc.)	- 14. Ra	ce - Americ		
s afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Y Year or Dates:	No		1□Yes 2No	Specify:		Specif	WE	HITE	
hour Itural	ed t	15. Decedent's		-	16a Decec	lent's Usual Occup	nation		16b. Kind of B	uoinace/la	advoter.	
iin 72 n "na Medic	plet	(Specify only highest	grade completed)		(Give	kind of work done OO NOT use retired	during most of wor	king	TOD. KING OF B	usiness/iii	dustry	
d with giene sr tha the l	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	OWNE	₹			SEVEN N	ATLE '	MARKET	
e file al Hy othe vent,	Be C	17. Father's Name (First, Middle, La	st)				18. Mother's Nam	e (First, Middle			I WHALL	
uld b Ments irked	2	ERNST		GU ⁻	TMAN		SOPHIE			KAUFI	MANN	
and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notifiled at		19a. Informant's Name/Relationship	,				and Number or Ru				Code)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		MARION GUTMAN / 1	V1FE				DRIVE - B					
ges 1 It of H If ite or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State			sition (Name of Ratory or other place NAS CHES	En 12/0	Date 3/2006	20c. Location RANDALL			
t. Pa rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Spe		p.i.e.v.				, i	INSON &			
Depa Depa Impo any it		21. Sign pure of Funeral Service Lic	ensee		22	. Name and Addre	STERSTOW	N ROAD .	- DIKESI	ITLLE	, MD 21208	
		23a Part1 Enter the disease or co	Sought Sough	t the death	Do not onto					1666	Arm Color	
		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final				· A		or respiratory a	rrest,		Approximate Interval Between Onset and Death	
Physician /Medical		disease or condition resulting in death)	a. Khen Due to (or as	mate	id	ung dist	ase				5 years	
Examiner			O B	consequen		hosis					Syears	
19.2 p.	Examiner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as			17.00		-			Syears	
be executed sician and burial-transit		Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
e exe ian al urial-t		Due to (or as a consequence of):										
ate b	Sica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown North										
death certificate k attending physic	/Me	IF FEMALE:	22a If you gutoomo	of program								
atten for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3□	Ectopic pregnancy	,		I	te of delive	ery Day Year	
the d y the ched	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	t time of dea	.ii 5	Other (specify)					,	
that ned by deta		Part II. Other significant conditions	contributing to death b	ut not resulti	ng in the un	derlying cause give	en in Part I.	23e. Did to	obacco use cont	ribute to th	he cause of death?	
quires n sign	d by							1 🗆 '	res 2 No	3 ☐ Prob	pably 4 Unknown	
aw require s been sig should b	Completed							24a. Was	an 24b.	Were auto	ppsy findings available	
The law cate has I	E O							autor perfo	rmed2	prior to cor death?	mpletion of cause of	
ian: rtifica	Be C	25. Was case referred to medical					26. Place of Deat	l ∏ Yes h (Check only a		1 □ Yes	2 1 0	
hysic nis ce direc	TOE	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	ent 2 EF	R/Outpatient	3 DOA Oth	ar.		dence 6 □Oth	er (Specif	v)	
ng Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		8b. Time of Injury	28c. Injur Worl	y at k?	28d. Describe I	now injury occur	red		
tendi eath. tor: A the fu	cati	2 Accident investigati 3 Suicide 6 Could not	bo				Yes 2 □ No	_				
or At ifter d Direc in by	Certification:	4 ☐ Homicide determine	d 28e. Place of Inju	ury - At home c. <i>(Specify)</i>	e, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rura	al Route Number,	
poital ours a neral filled		29a. Certifier 1 Certifying I	Physician: To the best	of my knowle	adne death	occurred at the tim	no, data and place	and due to the				
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner sta	t examinatioi	n and/or inv	estigation, in my o	pinion, death occur	red at the time,	date and place,	and due to	ated. the cause(s)	
ro th Nithin Sompl	Me	29b. Signature and title of Gertifier				29c. License	e number		29d. Date signe	d (Month, I	Day, Year)	
		19/1=		m	0	22	5-000				2,2006	
34	-	30. Name and address of person wh		eath (Item 23	3a) (Type, F	Print)	Bartina		becom	,1-01	_,	
12		Elamatin	mo S	mai	Huspi	tell of	Baltima	re.				
Sta		31. Date filed (Month, Day, Year)	MD S 32 Registra 005	ar's Signatur	e Land	The same						
Registr	ar	DEC 0 5 2	100 para	22, 45,45		5567						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 30, Physician LILLIAN GOREN 2006 Ρ 1:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FUTURE CARE CHERRYWOOD REISTERSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 🙀 F Hours 0270871918 MD 88 Director 215-32-1598 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits items 23a or 28a-f show the Medical Examiner must be notified Director BALTIMORE 1 X Yes 2 □ No MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 6908 FIELDCREST ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No WHITE Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Meany Injury or other traumatic event, the Meany once. Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL SECURITY ADMIN **CLERK** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SATTLER SKLAR **ESTHER JACOB** 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6017 KENNARD COURT - ELDERSBURG, MD 21784 KAREN KLEMPNER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State FORBAND CEMETERY 12/03/2006 ROSEDALE, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of) Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. within 24 hours after death To the Funeral Director:

> State Registrar

(Check only one)

29b. Signature and title

30. Name

ath (Item 23a) (Type, Print)

and manner stated.

32 Registrar's

who complete

2006

Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2, Diane Macey Gaskins Dec. 2006 2:08 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Towson Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗙 F 217-36-4050 Director 67 March 15,1939 Maryland Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2X No Director MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be r 1113 Justa Lane permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must by Funeral 21030 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) 12 Dog Breeder Dog Breeding 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Franklin Whitaker Williams Charlotte Mae White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Bowen Nelson/Sister 14 E. 21st. Street Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dec. 6. 20c. Location - City or Town, State Druid Ridge 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2006 Baltimore, MD Cemetery ervice Licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 21. Signature of Michael J. Flagle 10 W. Padonia Road Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy Por Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached for 9□Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Juknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy performed? Yes 22 No the Hospital or Attending Physician; after death.

Director: After this certific d in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) Lospec Hospital: \$ No 1 🗌 Yes 1 🔲 Inpatient ို 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Dean 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) **TP** (Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Filled hin 24 hours a +☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hour To the Fune completely fil Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. License number 29b. Signature, and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) harty St PS Donne 21264

no

32. Registrar's Signature

State Registrar \$1. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LISA Day Year GMFFIN 12:40 PM DECEMBER /Medical 2006 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST RANDALLSTOWN HOS PITAL Battimore If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 8. Date of Birth (Month, Day, 10-28-**Funeral** 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Months 214-84-2113 1 ☐ M 2 🛛 F Director MD Usual Residence of Decedent the Maryland State 10h. County wn or Location 10c City 10d. Inside City Limits notified Director more 1 ☐ Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be Brae or Items 23a Sonnie 21208 death v Funeral 12. Was Decedent Ever in U.S Açmed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian injury or other traumatic event, the Medical Examiner filed within 72 hours after Hygiene. Armed Forces: 1 XYes 2 ☐ No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life DO NOT use retifed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) OfNege (1-4or 5+) VYS marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic. ther's Name (First, Middle, La. Be 18 Middle Maiden nant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number er, City or Town, State, Zip Code, MD 21208 1/esville other 20a. Method of Disposition 20b. Place of Disposition cemetery, cremator 20c. Location - City or Town, State Burial 2 Cremation 3 F 3 Removal from State 21. Signature of Funeral Servi Lice 23a. Part1. Entertibe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC GERM CELL TUMOR ORIGINATING disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** FROM COLON METASTASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician ar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as IF FEMALE use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ρ Month 4□Pregnant at time of death Day Year 5 Other (specify) detached the 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 1 Yes 2 No 3 Probably 24a. Was an page 2 s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ► No autopsy perform or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Yes 2 🗆 No the f 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide in by t 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54352 2006 DECEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRCEA TODOR

Registrar
DHMH 17 Rev 1/2001

State

NORTHWEST

31. Date filed (Month, Day, Year)

COURT ROAD

RAWDALISTOWN

21133

HOSPITAL 5401 OLD

32. Registrar's Signature

Michael Herrington Griffin

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 2006 38483

Physicia	an/	Decedent's Name (First, Middle,Last)	2 Date of Death		3 Time of Death
ledical Exami	ner	Michael Herrington Griffin	November	26, 2006 Year	2000 hrs
C. S. Alexan		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of	Death	4c County of Death	
		Sinai Hospital Baltimore		n	/a
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under		h (MM/DD/YYYY) 9. 8ir	thplace (State or
Director		217-78-7459 $1 X M 2 F 43$	Min. 04-24-	·6)3, Foreig	n untry) MD
		Usual Residence of Decedent	<u> </u>		
aux		10a. State 10b. County 10c. City, Town or Location	·		10d Inside City Limits
nd thow	_	MD n/a Baltimore			1 X Yes 2 No
daryland 28a-f show 1 at once.	ector	10e. Street and Number 10f. Zip Code	10	g Citizen of What Cour	ntry?
th the Maryland 23a or 28a-f sho notified at once.		5440 Fairlawn Avenue 21215		II C A	
vith t	erall	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	n? (Specify Yes or No-	USA 14 Race - Ameri	can Indian, 8lack,
eath v item	ne	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, F		White, etc	
ter de	Fune	3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 No specify		Afric Specify Amer	
urs af Tural	ğ	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kir	nd of work done	16b. Kind of 8usiness/l	ndustry
2 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		S S Recei	wohlog
36 hin 7 than edica	힏	2+ Telemarketing		p p vecel	vables
d wil	Ö		Name (First, Middle, M	aiden Surname)	
215-0036 be filed within 7 ttal Hygiene ked other than ent, the Medica	Be (Walter Griffin Sara	ah Herrin	oton	
21. Men Men c eve	ည	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	er or Rural Route Numb	per, City or Town, State	Zip Code)
MD 21215-0036 of 2 should be filed within 72 hours after death with the Maryland tith and Mental Hygiene m 27 is marked other than "natural", or items 23a or 28a-f she anumatic event, the Medical Examiner must be notified at once	-	Sarah Griffin/Mother 5440 Fairlawn A	Avenue, B	altimore,	MD 21215
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical		20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c Location - City or	Town, State
nt of it. If other		1 X Burial 2 Cremation 3 Removal from State crematory or other place) Maryland National	12/4/2006	Laurel.M	Marvland
Baltimore, permit. Pages lar Department of Hee Important: If ite		4 Donate Jechy.			
Balti permit. Departm Importa			marie L/H	P.A. OF	Balto.Co.
Physician		9200 Liberty II A. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardifailure. List only one cause on each line.	diac or respiratory arres	allStown, st. shock, or heart	Approximate Interval
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68760, certificate be rding physici	2	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic p	pregnancy	23d Date of delivery Month D	ay Year
		past 12 months? 4 Pregnant at time of death 5 Other (Specify)	,	1	
Box e death c the atten ed for us	Physi	1 Yes 2 No 9 Unknown 9 Unknown			
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Division of Vital Records, P.O. Boy within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendence of the funeral director, page 2 should be detached for	Medical	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occu			
To the within to the comp	ledi	and manner stated			
	2	29b. Signature and title of certifier 29c. License number		29d Date signed (Mon	
7		famet Bruthell, M) O.C.M.E.		November 27, 20	U6
1		30. Name and address of person who completed cause of death (Item 23a)			
2		Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimo	re, MD 21201		
	tate	31 Date filed (Month, Day, Year) 32. Registrar's Signature			
Regist	ırar	DEC 0 5 2006 Research & Courte			

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	yland how		Usual Residence of Deced 10a. State 10b. 0			10c. Cit	y, Town or Lo	ocation	· · · · · · · · · · · · · · · · · · ·					10d. Inside City Limits
^	the Marylar 28a-f show	rector		Balti		Gy	wnn O		p Code			10g Citiza	n of What Co	1 O Yes 2 No
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27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Injury 28d. Describe how injury occurred Injury	i			
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The second secon	ner as stated.			
	ner as stated. d due to the cause(s)			
Byul MD P15979 11/29/20	ner as stated. d due to the cause(s) (Month, Day, Year)			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ner as stated. d due to the cause(s) (Month, Day, Year)			
Byryh MD P15979 11/29/20	ner as stated. d due to the cause(s) (Month, Day, Year)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Brenda GIDSON 3:25PM I November 2001 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Maryland Medical Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign
Country) **Funeral** Months 40 65 76 1 □ M 2 💢 F Davs Hours Director MARYIAND Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits BAltimORE 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? NS 5 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any filury or other traumatte event, the Medical Examine 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BIAC H 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HERPER PRIVET 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JEROME GIBSON 2 19a. Informant's Name/Relationship (Type. Print) OAVEnite 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BAltimore SHAW AUE 2/213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State 12/9/2006 BALLIMARE 4 ☐ Donation 5 ☐ Other (Specify) 2431 E OINER ST 21213 22. Name and Address of Facility 21. Signature of Funeral Service Licensee A WEATHER FORD FIS PA BALTOME 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dreast Metastatic vears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading L. Inning the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After : Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) November 28, 2006 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 1/2001

State

15852

MD 2120

ulie A Colodonato MD

31. Date filed (Month, Day, Year)
DEC 0 5 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

July A Colodovato

22 S Concerne Street Bultimore, M

32. Registrar's Sig

		For State Registrar		State	of Maryla	-	artment of rtificate o	Health and f Death		giene)	06	38487
The Market		1. Decedent's Name (Fir	st, Middle, L	ast)			·		2. Date of Dea Month	ith Day	Year	3. Time of Death
Physicia /Medic		Charles Ha	miltor	1					Novembe	r 14, 2	2006	11:20 PM
Examin	- 2	4a. Facility Name (If not	institution, g	ive street and nu	ımber)		4b. City, Town	, or Location of Dea	ıth	4c. County		
	e.,	Montgomery	Gener		ital	- In a to the first polar of	Olney		s. 8. Date of Birt		gome	ry place (State or Foreign
Funeral		5. Social Security Number		Sex 1 ☑ M 2 ☐ F	7. Age (in yr.	s. last birthday) Yrs.	Months Day			r, Year)	Cour	ntry)
Director		220-50-734 Usual Residence of Dec			37				UCL 14	, 1949	wasn	ington DC
yland now		10a. State 10b	. County		10c. 0	City, Town or Lo	ocation				1	10d. Inside City Limits
Mar a-f st	ţ	MD M	lontgo	mery		Silver	Spring					1 ☐ Yes 2√ No
th the	Oire	10e. Street and Number					10f. Zip Code	9		10g. Citizen of	What Cou	ntry?
23a	Ta I	2501 Muscr	ow Roa					20904		US		
after des	Funeral Director	11. Marital Status 1 ☐ Never Married	2 Married	Armed F	2 🗌 No		Was Decedent of If Yes, specify C	of Hispanic Origin? (uban, Mexican, Pue lo Specify:	Specify Yes or No- irto Rican, etc.)	Bla	ick, White,	
thours	ed by	3 ☐ Widowed 4 🔀	Decedent's	Year or I	Dates: 16	6-70	ident's Usual Occ	noiteous		16b. Kind of E	^{fy:} whi	
hin 72	Completed	(Specify of		rade completed, College) (1-4or 5+)	(Give	s kind of work do DO NOT use ret	ne during most of w ired)	orking			
giene giene r the	ĕ	unk	, (0,	unk			p1u	mber		home in		ement
d be file antal Hy ced oth	Be	17. Father's Name (First							_{ame (First, Middle,} nce Kathe			3
should ma Me mark	ို	19a. Informant's Name/				19b. Maili	ing Address (Stre	et and Number or F				
and 2 saith a n 27 is		Montgomery	Genei	al Hosp				e Philip				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Department of Heatin and Mental Hygiene. Department if Item 27 is marked other than "naturel", or Items 23s or 28s-f show eny injury or other traumatic event, Ite Maraical Exacting Train it a notified at ance.		20a. Method of Dispositi 1 Burial 2 Cr 4 Donation 5 X	emation 3		1 State		osition (Name of imatory or other p		Date	20c. Location	- City or To	own, State
permit. Departm Departm Imports ony inlu		21. Signature of Fynera	ald S	ensee Wade,	Direct			dress of Facility a tomy Boa:		Baltin	nore	Street
Physician		23a. Pay 1. Enter the di show, or heart fai Immediate use (Fina disease or condition	iure. List on	rications that ty one cause on	each line.	ath. Do not en	iter the mode of o	tying, such as cardi	ac or respiratory ar	,	erose.	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	1	Due to	(or as a cons	equence of):	11.0		- Cry			67 1118-
pe jis	lner	Sequentially list condition if any, leading to immediate. Enter Underlyin Cause (Disease or injurthat initiated events	ons, diate	b. Due to	(or as a cons	equence of):	0					3 le lejt d
ate be executed hysician and the buriat-transit	I Examiner	that initiated events resulting in death) Last		cDue to	o (or as a cons	equence of):						
physicate to physical streets	dical		,	d								
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 Yes 2 No 9 Unknown	ths?	1 Live	utcome of preg birth 2 Fe gnant at time o nown	etal death 3	□Ectopic pregna □ Other (s <i>pecify</i>)				ate of deliv	rery Day Year
requires that the sear signed by nould be detacted.	þ	Part II. Other significan	t condition:	s contributing to	death but not r	esulting in the	underlying cause	given in Part I.	23e. Did to	/_		the cause of death?
ne taw require has been si ge 2 should t	Completed									rmed?	prior to co death?	opsy findings available ompletion of cause of
ian: Ti ian: Ti rtificate	ပိ	25. Was case referred t	o medical	_	- V			26 Place of D	1 ☐ Yes eath (Check only o	20 No	1 🗌 Yes	2 No
Physician: Physician: rithis certifici	0 8	examiner?	o mosioa.	Hospital:	inpatient 2	☐ ER/Outpatie	ent 3 DOA	Othor	Home 5 Resid		her (Speci	ifv)
_ 0 0 0	atlon: T	27. Manner of Death 1 Natural 5	☐ Pending investiga	28a. Date (Mo	e of Injury onth, Day Year,		of 28c. l	njury at Work?	28d. Describe			,,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	ertific	2 Accident 3 Suicide 6 4 Homicide	Could no determine	t be 28e. Place	ce of Injury - A ding, etc. (Spe	t home, tarm, s cify)	treet, factory, offi		28t. Location (S City or Tox		nber or Rur	ral Route Number,
Hospit. 24 hours Funera etely fille	dicai C			aminer: On the				e time, date and pla ny opinion, death oc				
To the within To the compl	Me	29b. Signature an little	1 certifier	0	MD		29c. Lic	ense number		29d. Date sign	g/a (Month,	Day, Year)
		30. Name and address	of person wi	no completed car	use of death (I	tem 23a) (Type	Print)	din	cy M	10		
St	ate	31. Date filed (Month, L	ay, Year)	32.,	Registrar's Sig	gnature	6 .0		1			
Regist	rar	DE	C 0 5	2006 1	Altono	B. A.	marce?					

			1- State of Maryland / Department of Health and Mental Hyglene Certificate of Death Reg. No.	06 38488
	Physicia		1. Decedent's Name (First, Middle, Last) ARTHUR JACKSON HOWELL, SR. 2. Date of Death Month Day November 30	Year 2006 4:00 PM
9	/Medic Examin Funeral Director	er	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltmore 4c. County N/A 5. Social Security Number 412-46-6758 6. Sex 72 Yrs. 4b. City, Town, or Location of Death Baltmore 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min. 1 Under 1 Year Min. 2 Under 1 Year Min. 3 Under 1 Year Min. 4 Under 2 Hrs. 4 Under 1 Year Min.	
		tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Glen Burnie	10d. Inside City Limits 1 ☐ Yes 2 🛱 No
	th with the 23a or 28a	I Direc	10e. Street and Number 103 G Governor's Court 10f. Zip Code 21061 US.	
980	hours after death with the Maryland turel', or Items 23a or 28a-f ahow al Expuding must be notified at	Completed by Funeral Director		ce - American Indian, ck, White, etc. cy: White
Baltimore, Maryland 21215-0036	within 72 ine. Ihan "nai	ompleted	(Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use ariting)	usmess/Industry rn Electric Co.
and 2	2 should be filed v end Mental Hygie I a marked othar I raumatic avant, III	To Be C	17. Father's Name (First, Middle, Last) Edmond Nathan Howell Lillie Bell Grindsta	•
Mary	ges 1 and 2 should t of Health end Men if Itam 27 ia merke or other traumatic	F	19a. Informant's Name/Relationship (Type, Print) Arthur Jackson Howell, Jr. (Son) 721 Hook Rd., Westminster, Md. 2115	
imore,	permit. Pages 1 and Depertment of Health Important: If Itam 27 any Injury or other t once.		20a. Method of Disposition 1	- City or Town, State ge, Maryland
Balt	permit. Depertrimports any Inju		21. Signature of Funeral Service Licensee Kevin E Ecker 2MMM1744P814Fillak Funeral Home, P 237 E. Patapsco Ave., Balto., Md	.A. 21225-1856
.,9	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death
Howell P.O. Box 68760, 4	the death certificate by the attending phys ached for use as the	Completed by Physician/Medical	in the past 12 months? 1	ate of delivery onth Day Year
Ords,	w requires that been signed should be del	ted by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No	tribute to the cause of death? 3 Probably 4 Unknown
A Fee		Comple	performed2	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
₹ Vita	ysician: Th is certificete director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital: Description of Death (Check only one)	
Arthur Division of Vital Record	g Ph ter th neral	ation: To	1 Yes No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 7 Nursing Home 7 Nursing Home 7 Nursing Home 7 Nu	
Divis	or Atta elter de Diracto in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)	per or Rural Route Number,
	na Hospital n 24 hours na Funaral pletely filled	Medicai (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mix one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mix one)	anner as stated. and due to the cause(s)
•	To tha within 2 To tha comple	X	1 how James MD D18587 NOV 3	30 Z00 6
_	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL GORMEY GOD CATON AUE BUTINATE WD 2	21229
	Sta Registi		31. Date liled (Month, Day, Year) 32. Registrar's Signature	

			1 - State Amend #29d	State of Marylar Per Phy g862 1	nd / Depa 2/05/09	artment Hificate	of He	ealth ar Death	nd Me	ntal Hy	gienę Reg. No.	2006	38489
			Decedent's Name (First, Middle, La.							. Date of Dea	ath		3. Time of Death
	Physicia		STANLEY TUI	RONE HENDER	25011					Month //	Day 25	- Year 2006	0619AM
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, To	own, or L	ocation of	Death		4c.	County of Death	
			UNIVERSITY OF MAKE	YLAND MEDICAL	CENTER	/	SAI	Tim	ORE	-			
	Funeral		5. Social Security Number 6. S	iex 7. Age (In yrs.		If Under 1 Months	Year Days	If Under 24 Hours	4 Hrs. 8	Date of Birt	h v. Year)	9. Birth	place (State or Foreign
	Director		214-64-5354	MM 2□F 47	Yrs.	WIOTHITS	Days	Tiodis	0	(Month, Day	5	9	MD
7	1000		Usual Residence of Decedent 10a. State 10b. County	10c C	ty, Town or Lo	cation							10d. Inside City Limits
9	od a	5	MD NA		Baltin								X□Yes 2□No
4	or 28a-f ahow	Director	10e. Street and Number		Darcin	10f. Zip C	`ada				10a Citi	zen of What Cou	into/2
4	s alel death will the way ye ", or Itama 23a or 28a-f ahov kammar must be notified at	눕		D		101. 210 0		220					, .
1	Itama 23a	Funeral	2727 Northshir	12. Was Decedent Ever in L	J.S. 13. V	Was Deceder		230 Danic Origi	n? (Speci	fy Yes or No-		U . S . A . 14. Race - Amer	ican Indian,
	The same	Ξ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ZNO		If Yes, specify	y Cuban	, Mexican,	Puerto Ri	can, etc.)		Black, White	
3		by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes X	□No	Specify:				Specify: Bl.	ack
5	"natural, or	Completed	15. Decedent's E	ducation	16a. Deced	dent's Usual	Occupat	ion	of working			nd of Business/I	
֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Wed	De e	(Specify only highest gra	Cotlege (1-4or 5+)	life.	DO NOT use	retired)	ining most c	JI WOIKING		MD .	Reloca	ters
7	gien er th	Ö	10th grade	na		Move					Mov		
3	is laygion. Is Hygion than "natural", or itama 23a or 28a-f ahow of other than "natural", or itama 23a or 28a-f ahow avent, the Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last,)						First, Middle,	Maiden	Sumame)	
7		ို	Alexander Hend	lerson	7		I	Ethel	l Wa	tts			
ָּבָּ לַ	n and Mental Hygiene. 7 is marked other than reaumatic avant, tha M		19a. tnformant's Name/Relationship (-	Town, State, Zi	•
	of health and Menitem 27 is market traumatic		Kimberly Hende		Place of Dispo			nire	Dri			cation - City or T	Md 21230
5	nent of h		20a. Method of Disposition 1 XBuriat 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crer	matory or oth	er place,						
	ntmer ntant njury		4 Donation 5 Other (Special 21, Signature of Funeral Service Lices		ng Men	noria. 2. Name and				/06	Ra	ndalls	town, Md
מ	perint. reges I and a Depertment of Health a Important: if Itam 27 is any Injury or other tra		21, Signature of Furieral Service Lice	~ X	N	March	F/I	H Wes	st				
			23a, Part1. Enter the disease, or com	plications that caused the dea								re, md	21215 Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.									Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a. Due to (or as a conse	RED	IMM	UN	DEF	ICIEN	164) YN	DROME	YEARS
	xaminer	Н		Due to (or as a conse-	querice ory.								
		ē	Sequentially list conditions, if any, teading to immediate	b. Due to (or as a conse	quence of):								
).	nd nd ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	C									
5	icien and burial-Iransit		resulting in death) Last	Due to (or as a conse	quence of):								
	ys he	Physician/Medical		d									
0	ing p e as t	Med	tF FEMALE:										
לא מ	ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. tf yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	at death 3 ☐	Ectopic prec					2	3d. Date of delin	very Day Year
5	the e	/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□ Unknown	death 5∟	Other (spec	cify)						,
	ing law requires then the death certificate are hes been signed by the ettending physpage 2 should be detached for use as the		Part II. Other significant conditions	contributing to death but not re-	sulting in the u	ndertving cau	use giver	n in Part I.		23e. Did to	obacco u	se contribute to	the cause of death?
colds,	sign d be	d by	RENAL FAL	LURE		, ,				101	res 2[No 3□Pro	bably 4 Unknown
5	peen	ete								24a. Was	20	24h Wara aut	oney findings available
ָבָּי בָּינִ ב	hes ge 2	Completed								autop		prior to o	opsy findings available ompletion of cause of
ומ	ficete or, par	င္ပ	25. Was case referred to medical					00 BI	15 11 1	1	2 □ No	1 ☐ Yes	2 No
5	certi	m	examiner?	Hospital: 1 Minpatient 2] ER/Outpatier		Other			Check only o		G □Other (Spec	4.1
5	ar this eral d	7. To	27. Manner of Death	28a. Date of tnjury	28b. Time of		c. Injury			d. Describe h			'' y)
5	ath.	읈	1 Natural 5 Pending 2 Accident investigatio	(Month, Day Year)	Injury	м		es 2 □ N	0				
2	r dea	€	3 ☐ Suicide 6 ☐ Could not be determined		nome, farm, str	reet, factory,	office		28	f. Location (S City or Ton			ral Route Number,
5	s efter	Certification;	4 Hollicide	building, etc. (Spec	(Y)					Only or You	m, State)		
	To the nospitel or death. To the Europeal Overseller death. To the Europeal Directors After this certificate hes been signed by the eltending placement of the function of the Europeal Overseller death. Completely filled in by the funeral director, page 2 should be detached for use as to	edical	29a. Certifier 158. Certifying Pl	nysicien: To the best of my kn miner: On the basis of examin	owledge, deatl	h occurred at	the time	e, date and	place, an	d due to the	cause(s)	and manner as	stated.
	the F	ed	one)	and manner stated.	211071 2110 07 111							piaco, and doo	
	7 V V V V V V V V V V V V V V V V V V V	Σ	29b. Signature and title of certifier	1)	7 .	29c.	License	unmper	115		29d. Gat	2/04/200	6 (Agent)
					mo		-	20	10) +	1/16	12006	9
	3		30. Name and address of person who				5	a.	17.	10.0		17 6 .	
			3TACY KENNI 31. Date filed (Month, Day, Year)	32. Registrar's Sign	L S. GR	LEENE	٥,,	DA	110.	MD.		1201	
	Sta Registr		DEC 0 5 200	06 Roman Si	Sale and the sale	22							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2006 6:05 РΜ Hall December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In vrs. last hirthday) Funeral 1 □ M 2 🔀 F Days Hours 218-18-5382 83 Director July 28,1923 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov idical Examiner must be notified at Maryland Baltimore Dundalk 1 ☐ Yes 2 X No Director 10e. Street and Number 10f, Zip Code 10q. Citizen of What Country? 7841 21222 USA Rockbourne Road within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No à Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Auto Company 12 years Clerical Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill treent of Health and Mental Heart: If Item 27 is marked out Henry W. Powell Pansy M. Booth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Nevins Daughter 7841 Rockbourne Road, Dundalk, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) December 6, 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Injury or permit. Page Department o Important: If any Injury or Baltimore National Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to for as a consequence of): disease or condition resulting in death) days /Medical Examiner hemodyalysis in Fection weeks Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>}</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform certificate 2 No 1∐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 6 Nother (Specify) WSPC4 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death. 2 ☐ Accident completely filled in by the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital within 24 hours a Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D58303 December 3 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DRIVIE 17 FeV 1/2001

31. Date filed (Month, Day, Year)

Charles mo

32. Registrar's Signature

6565

N.

ORIGINAL

Barnone

			1 - For State Registrar	State of Mar		artment of H			iene 19. No 2006	38491	
	Physic: /Medi		1. Decedent's Name (First, Middle, La Daniel C. Harzarik	•				2. Date of Deat Month No	Day 2006	3. Time of Death	
1	Examir		4a. Facility Name (If not institution, given 1078 MINNETONKA RD	ve street and number)		4b. City, Town, or SEVERN	Location of Death		4c. County of Death		
	Funeral Director			Sex 7. Age 1 N 2 F XX	(In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, MAY 9, 19)	Year) 9. Birth	place (State or Foreign ntry) MD	
	e Maryland 3a-f ehow tiffed at	Director	10a. State 10b. County MD ANNE ARUI		Oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
10	be filed within 72 hours after death with the Maryland that Hygiene. Idea office then "naturel", or items 23a or 28a-1 show event, the Mudical Examinar must be rotified at	Funeral Dire	10e. Street and Number 1078 MINNETONKA - RD 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 Yes 2 No	er in U.S. 13. 1	10f. Zip Code 21144 Was Decedent of Hi f Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert		USA 14. Race - Ameri Black, White	ntry? can Indian,	
Maryland 21215-0036	nin 72 hours a n "naturel", or Vedical Exam	Completed by I	3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr	Year or Dates: ducation ade completed)	16a. Deced	1 ☐ Yes XX☐ No dent's Usual Occupa kind of work done d DO NOT use retired;	ition	king	Specify: Will 6b. Kind of Business/Ir	HITE	
and 212	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other then "other traumatic event, the Mar	Be	Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last	College (1-4or 5+)		STERER		ne (First, Middle, M	FURNITURE faiden Sumame)		
e, Maryl		P.	WILLIAM HARZARIK 19a. Informant's Name/Relationship (DIANA RUTH PHELPS	Туре, Print) DAUGHTE	R 4116	APPLE LEAF		ral Route Number, ENA, MD 2111	City or Town, State, Zip	o Code)	
Baltimore,	t. Page rtment o rtent: If njury or		20a. Method of Disposition XX Burial 2	(y)	MEADOWRIDG	E CEMETERY 12.5.20 Name and Address of Facility		2006	ELKRIDGE, MD	ation - City or Town, State	
B	permi Depa Impo any ii		23a. Part 1 Enter the disease, or bor shock, or heart failure. List only	plications that caused th	FI 1148 42	NK FUNERAL G CRAIN HWY	HOME, P.A. SW GLEN B	BURNIE MD 21	1061 st,	Approximate Interval Between	
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P.O. Box 68	ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 (4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year	
ords, P	w requires that the de been signed by the should be detached	þ	Parl II. Dther significant conditions of End stage C	contributing to death but of	outing to death but not resulting in the underlying cause given in Part I. while Ohs Will the Curp Disease			23e. Did toba	acco use contribute to the 2 No 3 Prob	ne cause of death?	
ital Rec	an: The law tificate has t tor, page 2 s	e Completed	25. Was case referred to medical				26 Place of Deet	24a. Was an autopsy perform 1 Yes 2 sth. Check only one	ed? prior to condeath?	psy findings available inpletion of cause of 2 No	
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b			3 DOA Other	4 Nursing Ho	ome 5 Residen 28d. Describe how	ice 6 □Other (Specifi v injury occurred		
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29b. Signature and title of certifier	and manner stated	amination and/or inv	estigation, in my opi	nion, death occur number	red at the time, dat	e and place, and due to	the cause(s)	
,	V		30. Name and a dress of person who	completed cause of deat		Print)	0470	10	MD 211		
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar's		ighway	rasa	deno	M all		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTRM#4C&20b, perFH, G862, 12/5,006, ws State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) Physician ROBERT DECEMBER **HOFFMAN** 2006 P M 5:25 /Medical 4a. Facility Name (If not institution, give street and number) 4c. CourBATTTMORE 4b. City, Town, or Location of Death Examiner GENESIS ELDERCARE RANDALLSTOWN -BLATIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 5. Social Security Number Birthplace (State or Foreign Country) Days V M 2□F 12/29/1936 Director 216-34-1091 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE MD RANDALLSTOWN 1 □Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9323 TULSEMERE ROAD 21133 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 ☐ Yes 2 🕅 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER AUTO SALVAGE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARRY **HOFFMAN** W LILLIAN ဥ SNYDER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9323 TULSEMERE ROAD - RANDALLSTOWN, MD 21133 BARBARA HOFFMAN / WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 12/4/06 1 X Buriat 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) OUDON MEMORIAL PARK CATONSVILLE, MD 11/04/2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Endstage disease on Henodialysis rengl /Medical Due to (or as a consequence of): Examiner mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Per and Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, Physician/Medical rebrav accident ascular IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ propharyneel 1 ☐ Yes 2XNo 3 Probably 4 Unknown Be Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ∐ Yes 2**№** No 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) after death. 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 XNo in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D30115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Old C+ Rd Randellstown mp 21133 5311 hiokpeh mo 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

		1 - For State Registrar		Ce	ertificate of	Death	, ,	eg. No.	
Dhysia		1. Decedent's Name (First, Middle, Last)					2006	3. Time of Death	
Physic /Med		Claire Hattendorf					2006 Year	9:45a M	
Exami	ner	4a. Facility Name (If not institution				or Location of Death		4c. County of Death	
	a ,		heran Villag			minster		Carro	
Funeral Director	•	5. Social Security Number 293–28–7485	6. Sex 7. Ag 1	e (In yrs. last birthday 72 Yrs.	// If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug • 27	Year) 9. Birth Cor	place (State or Foreign ntry) 110
and www.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
Maryl f sho	ŏ	Md. Baltin	ore	Reist	erstown				1 □ Yes 2 □ Ño
the 28a-	Director	10e. Street and Number		<u> </u>	10f. Zip Code		10	Og. Citizen of What Cou	ntry?
3a or	0	327 Norgul	f Rd.			136		U.S.A.	,
deatl	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ameri	
ING 21215-0036 be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	No	1 ☐ Yes 2 No		rican, etc.)	Specify: White	
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Baltimore, Maryland 21215-9036 permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. mportant: if item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance.	70	19a. Informant's Name/Relations Erich R. Hat	hip (Type. Print)	19b. Mail	ling Address (Street	and Number or Ru Rd. Reis	ral Route Number,	City or Town, State, Zi	Ç Code)
e, l 1 and Healt Healt ther 1		20a. Method of Disposition	Zendori – nak					20c. Location - City or T	
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Baltim permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Other (5 21. Signatur o Fune al Service		Dulaney	Valley Me	m. Garden	s Dec. 6	,2006 Timor	num, Md.
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/Medical Examiner		resulting in death)		a consequence of):					_
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death o	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify) _	у		23d. Date of delive Month	ery Day Year
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fran Jan: Jan: rtiffica	a l	25. Was case referred to medica				26. Place of Deat	1 Yes 2 h (Check only one	No 1 ☐ Yes	2 No
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DIVISION al or Attending s after death. I Director: Afte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ury - At home, farm, st c. (Specify)	treet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	d Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifyii (Check only 2 Medical	ng Physician: To the best of Examiner: On the basis of and manner sta	f examination and/or i	th occurred at the tin nvestigation, in my c	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner as s te and place, and due t	tated. the cause(s)
To 1 To 1	M	29b. Signature and title of certified	Tryamo		29c. Licens	e number 5170 S	29	d. Date signed (Month,	Day, Year)
2		30. Name and address of person	m De I	m. PANS	(AVIA)	West	mintes	12-4-0 - , mD 2	157
St Regist	ate rar	31. Date filed (Month, Day, Year)	32 Aegistra 2006	ar's Signature	ade				
		200 min or or or							

DHMH 17 Rev 1/2001

06-09159 Hamel Hurley

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State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		n iviai yianu		ficate of		a Wientar Fr		g. No	200	6 38491
Physician/ ledical Examiner		Decedent's Name (First, Middle,Last) Hamel				Hurley	7		Date of Dear Month December		Year	3. Time of Death 2317 hrs
4a. Facility Name (if not institution Johns Hopkins Hospita			ot institution, give	street and number) 4b. City, Town, or Location of De. Baltimore City					December		ounty of Death	
Funeral		5. Social Security Numb	· ·	7. Ag	ge (In yrs. last	birthday)	If Under 1 Year	If Under 24Hrs	8 Date of Bir	th (MM/DD		hplace (State or
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after de	by Fu	3 Widowed		Yes, Give Year	X No		Yes 2X No					ack
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21215-0036 uld be filed within Mental Hygiene marked other tha	رة Be	Andrew	it, Middle, Last)	C.	H	urley		18.Mother's Name Maure		iaiden Sui	name) B	oyce
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	edical	one) 2 Med	dical Examiner: C	on the basis of examed manner stated.			on, in my opinion,	death occurred at				
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	ŀ	30. Name and address	of person who co	mpleted cause of d	leath (Item 23	ia)	0.0.1			Decell		
0		Ana Rubio MD.		Medical Exam		1 Penn St	treet, Baltimo	re, MD 21201				
Sta Registr	, c		0 5 2001	407	r's Signature	BOOM	20					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Isaac Hill 12 2006 7:50 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Futurecare - MGH Baltimore City If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1**X** M 2□ F Months Days 223-36-4696 73 VA 07/11/1933 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location r 28a-f show notified at 10a. State 1X∏Yes 2∐No MD Baltimore City Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or adical Examiner must be 1613 W. Harlem Avenue 21217 USA Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. 11. Marital Status 1X Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify. Baltimore, Maryland 21215-0036 Specify:African American þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " College (1-4or 5+) Elementary/Secondary (0-12) 6 school teacher Baltimore County School System 12 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen Vernell Johnson Calvin Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12505 Trelawn Terrace; Bowie, Maryland 20721 Sherman Hill / Nephew Department of Health Important: If item 27 any injury or other tr once, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Cemetery: 12/12/2006 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and Division or Vital Records, P.O. Box 68760, Physician/Medical the 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 1 🗌 Yes Completed peen s 245. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy certificate 1□ Yes 2 110 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3□ DOA 1 ☐ Yes Certification: To this 27. Manne Death 28b. Time of 28c. Injury at Work? 28a, Date of Injury 28d. Describe how injury occurred (Month, Day Year) 1 C atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not b 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determi 4 ☐ Homicide 1 Prifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical

10

State

29b. Signature and title of certifier

30. Name and addre

31. Date filed (Mor

DHMH 17 Rev 1/2001

death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6Vember Nancy Jennings 26 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Saltimor 21791 If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 ₹ F Months Days Hours Yrs. 65 June 29, Director 220-36-4205 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other then "neturet", or itema 23s or 28s-1 show any hjury or other treumatic event, the Medical Examiliar Livel be notified at once. MD Baltimore 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2801 Rayner Avenue 21215 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: black 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk Be ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sinai Hospital 2401 W. Belvedere Avenue Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ₺ Other (Specify) in state State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD Approximate Interval Between Onset and Death Enter the disease or complications that or heart failure. List only one cause on his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner ed by the attending physicien and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No 2 No 1 ☐ Yes After this certification of funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Medical Certification; To 1 ☐ Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending efter death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funeral [Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item-23a) [Type EM

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

2006

Registrar's Signature

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician MILDREN BEATRICE WILLIAMS JOKE 10:15AM DEC 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MANOI CAVE (WOODBriDGE CATONSUILCE BALtiderE 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1□M 20 F Days Director 12 5/10 HARYIAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov Be Completed by Funeral Director r⊠es 2 No BALHRORE MARGIANO 10e. Street and Number 10g. Citizen of What Country? must be BRIDGEVIEW READ 23a USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner. once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: If Yes, Give Year or Dates: Specify: Black 3 Widowed Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4EArs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAMS ALICE HORSEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EUGENE ROBD Junes Konos/Ishus ald 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State Marylano NATIONAL Momerial Park 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CNA TOTAN - H BYTH FUNE A WORK 21. Signature of Foneral Service Licenses yare 5240 REILTERTHUND RUND 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) HYPERTENSIVE CARDIOVASCILLAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be debached for use as the burial-transit in by the funeral director, page 2 should be debached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Division or Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DIABETES MELLITUS 1 Tyes 2 □ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 12 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Matural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D005910 12-4-06 MD 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS CENTER DRIVE REISTERSTOWN MP UMA, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	Months Days Hours	24 Hrs. 8. Date of Birth (Menth, Day, Ye	ar) 9. Birth	place (State or Foreign		
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a	icien: The certificate ha		05 W			1 ☐ Yes 2 📉		2 X No		
₹		o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospita	al: 1 ☐ Inpatient 2 ☐ ER/Ou		of Death (Check only one)				
ō	Phys ar this eral di	1: To		a. Date of Injury 28b.	Time of 28c. Injury at	rsing Home 5 Residence	6 ∐Other (Specify iury occurred	1)		
ion	Attending I r death. ector: After by the funer	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	njury Work? M 1 ☐ Yes 2 ☐ I					
Division	or Attendi after death. Director: A in by the fu	ifica	a Could not be	a. Place of Injury - At home, fa	ırm, street, factory, office	28f. Location (Street	and Number or Rura	l Route Number,		
Ö	tel or A s after al Dire ed in b	Certification:	4 _ Homede	building, etc. (Specify)		City or Town, Sta	.10)			
	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai (29a. Certifier 11 Cartifying Physician (Check only 2 Madical Examiner: C	To the best of my knowledge	e, death occurred at the time, date and d/or investigation, in my opinion, deat	d place, and due to the cause(s) and manner as st	ated.		
	To the H within 24 To the F complete	Medi	one) a	nd manner stated.						
	To To com	2	29b. Signature and title of certifier		29c. License number		ate signed (Month, L			
7	1		who was		1900 UT	(15 NO	JEmgen	29 2006		
11	14		30. Name and address of person who complet	ed cause of death (Item 23a)	(Type, Print) WILL GUSAGE #	257 Day	- L.O.	7/27 8		
U	Sta	to	31. Date filed (Month, Day, Year)	(CD) A		> T DHCIMON	CO MY Z	, ,		
	Registr	-	DEC 0 5 2008	.30	Spelas					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 38500 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day NOVEMBER 30 Year JENKINS PATRICIA 03:23 AM 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE HOSPITAL HARBOR If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 1□M 20 F Months Yrs. 213-62-935 51 Usual Residence of Deceden 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a. State 1 PYes 2 No Mo DAITIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2122 SOAd 4502 OKE Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. 11. Marital Status Black, White, etc Specify: BlACK 1 Never Married 2 Married 1 ☐ Yes 2 No 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SHATE URSE 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) AnIEL W 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural , oute Number, City or Town, State, Zip Code) Rd. 2/229 Kins 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stale 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State D006 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Zun. of Eaging on E 21 c md. 21213 adams Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final - source Unknown SEPSIS 1 Week disease or condition resulting in death) Due to (or as a consequence of): HIV/AIDS 5 Years if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES MELLITUS 14P6 II 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 Ø No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No HYPERTENSION 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural

Examiner Se as the or Attending Physician: The law requires that the deeth certificate be executed. burial-transit Box 68760, Physician/Medical use as the ed by the e Division of Vital Records, P.O. sete hes been signed by page 2 should be detacl Completed by this certificete Be Certification: To After thi funeral of s effer dec. filled in by

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

2

Funeral

Director

ui Hygiene. Tother then "neturel", or iteme 23a or 28a-1 ehow vent, the Medical Exercitær must be notified at

lith and Mental Hygie 27 is marked other r traumatic event, III

permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic eveni once:

Physician

Examiner

/Medical

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

2 Accident

3 Suicide

4 | Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

28c. Injury at Work? Injury 1 Yes 2 No

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

Mamusa, MB

29c. License number RES 700

29d. Date signed (Month, Day, Year) NOVEMBER 30, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARBOR HOSPITAL, 3001 SOUTH HANDVER STREET, BALTIMORE NITATIN; AMUSA 31. Date filed (Month Cay, Year) 2806

State Registrar egistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

within 24 hours e To the Funerel Completely filled

÷

Medical